Preliminary Draft

Health Promotion and Disease Prevention Services Chapter

District of Columbia State Health Systems Plan

State Health Planning and Development Agency
District of Columbia
Department of Health

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HEALTH PROMOTION DISEASE PREVENTION
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HEALTH PROMOTION AND DISEASE PREVENTION

Health promotion and disease prevention are two of the 'core services' of health care in the District of Columbia. The District of Columbia Department of Health (DOH) holds far-reaching responsibility for promoting healthy lifestyles and preventing the transmission and progression of disease among residents and visitors to the city. Health promotion and disease prevention depends on data for the effective identification, tracking and assessment of health status and illness. To achieve the District's goals for a healthier population, health assessments and information-gathering activities must be effectively married to health education and health system planning.

The mortality rates for many preventable conditions are higher in the District of Columbia than the national average. Sizeable segments of the District's population are more vulnerable to disease and unhealthy lifestyles as a result of poverty, homelessness, substance abuse, age, and other factors. Illnesses more prevalent in the District of Columbia than in the nation as a whole include heart disease, cancer, diabetes, HIV/AIDS, and asthma.

To improve the health status of District residents, health promotion and disease prevention must have the goal of eliminating health status disparities between racial and ethnic groups. The Health Resources Services Administration (HRSA) of the U.S. Public Health Services defines disparities as "a population-specific difference in the presence of disease, health outcomes, or access to care" (November 2000). Improving the health of all District residents requires targeted information and the delivery of health services that counter misperceptions about healthy practices and enable individuals to gain access to health services, despite language and other barriers.

I. DISEASE PREVENTION AND LIMITING THE EFFECTS OF CHRONIC DISEASES

Disease prevention activities can be loosely grouped into three categories: 1) Pre-disease (primary disease prevention) -- activities whose emphasis is on services that prevent the occurrence and reoccurrence of illness and disease; 2) Latent Disease (secondary prevention) -- targeted services that aid individuals and providers in better managing chronic illness and prevent or delay the condition's worsening; and 3) Symptomatic Disease (tertiary prevention) -- efforts that encourage individuals, particularly those with personal or family histories of chronic disease, to seek early and appropriate care. Table 1 outlines the levels of disease prevention.

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Table 1: Levels of Disease Prevention

Stage of Condition/Disease	Level of Prevention	Response	Approach
Pre-disease	Primary	Health education and specific protection to the individual, the community and from the environment	Elimination of causes of disease or resistance to disease
Latent Disease	Secondary	Presymptomatic diagnosis, patient and provider partnership in preventing disease and condition worsening	Diagnosis and interruption of disease process
Symptomatic Disease	Tertiary	Encouraging early and appropriate care	Limit the physical and social consequences of symptomatic disease

Adapted from Leavell, H.R. and E.G. Clark. Preventive Medicine for the Doctor in His Community, 3rd ed. New York, McGraw- Hill Book Company 1965.

A. District of Columbia Healthy People 2010 Goals, Objectives, and Strategies for Disease Prevention and Health Promotion

Cited in the Health Profile chapter of this document, the District's Healthy People 2010 Plan presents strategies that address prevention practices from prudent dietary choices/ weight management (primary prevention), early detection of chronic disease symptoms (secondary), and disease management (tertiary). A list of the leading causes of death according to 2010 Objectives presents the course of action proposed to reduce mortality among residents by the year 2010.

Five Leading Causes of Death in the District of Columbia in 2000 and Corresponding DC Healthy People 2010 Objectives.

1. **Heart Disease:** Crude mortality rate for all residents: 273.7 per 100,000 people.

   DC Healthy People 2010 Objective 15-1: Reduce deaths from heart disease to no more than 210.5 per 100,000 people (Baseline: In 1997, the age-adjusted mortality rate for heart disease for 263.2 per 100,000 people.

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2. **Cancer:** Mortality Rate for all sites for all residents: 232.2 per 100,000 people.

DC Healthy People 2010 Objectives for Cancer:

- **Objective 12-1**: Reduce lung cancer mortality in the District of Columbia to an age-adjusted rate of no more than 40.2 per 100,000 residents.
- **Objective 12-2.1**: Decrease the age-adjusted mortality rate for breast cancer to no more than 24.4 per 100,000 people (Baseline: The age-adjusted mortality rate for breast cancer in the District in 1997 was 29.1 per 100,000 residents).

- **Objective12-2.2**: Decrease the age-adjusted mortality rate from cervical cancer to no more than 0.88 per 100,000 residents (Baseline: 2.2 per 100,000 residents).

- **Objective 12-3**: Reduce colorectal cancer mortality to an age-adjusted death rate of no more than 12.2 per 100,000 residents (Baseline: 17.7 per 100,000 residents in 1997).

- **Objective 12-4:** Reduce the prostate cancer mortality rate for African American men to no more than 24.4 per 100,000 residents.

3. **Essential Hypertension:** Mortality Rate for all residents: 41.3 per 100,000 people.

DC Healthy People 2010 Objectives for Hypertension:

- **Objective 15-2**: Reduce the proportion of adult residents with high blood pressure to no more than 10% (Baseline: 19.3% of adults residents reported being diagnosed with high blood pressure in 1997 according to the Behavioral Risk Factor Surveillance Survey or BRFSS).

- **Objective 15-3:** Increase to at least 50% the proportion of adult residents with high blood pressure whose pressure is under control (Baseline: Nationally 18% of persons 18years and older with high blood pressure had it under control [19% of African Americans in 1988-1994 according to the CDC/NCHS NHANES])

- **Objective 15-4**: Increase to at least 95% the proportion of people with high blood pressure who are taking action to help control their blood pressure (Baseline: Nationally, 72% of people with high blood pressure aged 18 and older took measures to control their blood pressure, such as medication and diet modification according to the 1998 CDC/NCHS NHIS).

- **Objective 15-5:** Increase to 100% the proportion of adult who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high (Baseline: 97% of District residents reported having had their blood pressure checked within the past two years in the 1994 BRFSS).

4. **Cerebrovascular Disease (Stroke):** Mortality Rate for all residents: 39.5 per 100,000 people.

   - **DC Healthy People 2010 Objective 15-8**: Reduce the rate of deaths from stroke to no more than 43.2 per 100,000 people (Baseline: The age-adjusted death rate for stroke was 54.1 per 100,000 people in 1997 according to the CDC publication, "Chronic Diseases and Their Risk Factors: the Nation's Leading Causes of Death, 1999).

5. **HIV/AIDS:** Mortality Rate for males: 60.1 for females: 20.8.

   DC Healthy People 2010 Objectives for HIV/AIDS:

   - **2010 Objective 16-1.1:**Confine the annual incidence of diagnosed Acquired immune deficiency syndrome (AIDS) cases in the District to no more than 90 cases per 100,000 people (Baseline: 143 cases per 100,000 people in 1997 according to the CDC surveillance report).

   - **2010 Objective 16-1.2:** Increase by 40% the number of condoms distributed per year to District residents, especially among high-risk populations (Baseline 167,000 distributed in 1998).

   - **2010 Objective 16-1.3**: Facilitate the planning and delivery of training and capacity-building activities for community-based organizations involved in the direct provision of human immunodeficiency virus (HIV)-prevention services for high-priority groups.

   - **2010 Objective 16-2**: Reduce mortality from HIV/AIDS infection among District residents to no more than 15 deaths per 100,000 people (Baseline: The HIV/AIDS mortality rate in the District of Columbia was 46 per 100,000 in 1997).

   - **2010 Objective16-3. 1**: Increase the number of adolescents and adults who, although newly diagnosed with HIV, are already receiving early medical intervention and secondary prevention efforts in compliance with PHS treatment guidelines (Baseline: 850 clients accessed medication through the AIDS Drug Assistance Program (ADAP) in 2001 and 6,180 clients accessed primary medication related services).

- **2010 Objective 16-3.2**: Increase by 1,000 the number of newly diagnosed HIV-positive residents involved in secondary prevention programs (Baseline: 2,942 were involved in secondary prevention programs in the District in 1997).

- **2010 Objective 16-3.3**: Increase to 1,920 the number of persons dually diagnosed with HIV/AIDS and substance abuse who are enrolled in drug abuse treatment programs (Baseline: 96 dually diagnosed persons were enrolled in the District in 1998).

- **2010 Objective 16-4.1**: Increase to 30% the proportion of school children in middle school or junior high school who receive classroom education on HIV and sexually transmitted diseases (STDs) (Baseline: 24% in middle school and junior high school classes received HIV and STDs education in the classroom in 1998.

- **2010 Objective 16-4.2**: Increase the proportion of school children in high school who receive classroom education on HIV and STDs to 50% (Baseline: 43% in high school received HIV and STDs education in the classroom in 1998).

- **2010 Objective 16-5**: Increase by 21% the number of residents receiving HIV-antibody testing and counseling for injection drug users, including those in District jails and prisons (Baseline: A projected 25,4000 will have received such services in the District in 2000. 21,000 received HIV counseling services as of July 2001).

- **2010 Objective 16-6**: Increase the number of years of healthy life of an HIV-infected individual by extending the intervals of time between an initial diagnosis of HIV infection and AIDS diagnosis, and between that diagnosis and death (Baseline: The interval between first diagnosis of HIV infection and death from AIDS was 15-20 years in 1996).

- **2010 Objective 16-7:** Increase by 200% the number of tenant-based housing slots allotted to those with HIV/AIDS from 130 slots in 2000 to 500 slots in 2010 (Baseline: 380 tenant-based housing slots were allotted to persons with HIV/AIDS in 2000).

B. Population-Based Strategies For Primary Prevention

1. Tobacco Control

(Tobacco Use: DC Healthy People 2010 Chapter 2; federal *Healthy People* 2010 Chapter 27)

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The State program for tobacco control includes a coordinated plan for the utilization of Tobacco Settlement dollars developed with the expertise of a Tobacco Advisory Board and other interested stakeholders. The elements of a comprehensive plan include the four principal goal areas as well as activities targeting tobacco related chronic diseases, such as cardiovascular disease, bronchitis, and lung cancer. Expanded efforts at counter-marketing, prevention of youth initiation and increased availability of smoking cessation services also have been identified as five-year program objectives.

The following are the DC Healthy People 2010 Goals regarding tobacco use:

Goal 2-1.1: No more than 18.5% of adults are current smokers. (AIP, 2002)

Goal 2-1.2: No more than 20% of Hispanics in the District are current smokers.

Goal 2-1.3: No more than 50% of young people in grades 9-12 have ever smoked.

Goal 2-1.4: No more than 15% of young people in grades 9-12 are current smokers. (AIP, 2002)

Goal 2-2: 98% of pregnant women abstain from smoking.

Goal 2-3: 75% of patients receive advice to quit smoking from a health care provider during the reporting year.

2. Immunization

(Immunization and Infectious Diseases: DC Healthy People 2010 Chapter17; federal *Healthy People* 2010 Chapter 14)

A number of infectious diseases can be effectively prevented through vaccination. Several diseases have been essentially eradicated through vaccination, most notably polio and smallpox. However, until the point at which a disease is fully eradicated, continued mass immunization is necessary. When diseases are uncommon, there is little natural immunity in the population. A high level of vaccine coverage must be maintained – otherwise, a single case could rapidly infect others, leading to a possible epidemic. When vaccination levels fall below 85%, the risk of an epidemic is considerable. The challenge is to maintain public support for, and compliance with, vaccination programs against diseases that are not perceived by the public as an immediate threat.

The District's Immunization Program has four basic components:

1. Epidemiological tracking of vaccine preventable diseases
2. Public education to increase awareness of vaccination recommendations
3. Free walk-in immunization clinics and community immunization events
4. An immunization registry – a computerized database that tracks the immunization history of all District children. Doctors, nurses and families voluntarily report immunization status of children to the registry.

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A. Vaccination for Pediatric Conditions
Measles, mumps, rubella, pertussis and diphtheria were once common in the United States, but are now seen rarely. In their time, these diseases were common causes of blindness, deafness, sterility, pneumonia, stillbirth and childhood death. Effective vaccines for these conditions have been in widespread use in this country since the 1960's. Vaccines have become available for varicella (Chicken Pox) and Haemophilus Influenzae, which are also common in childhood. These vaccinations have been added to the standard list of recommended childhood vaccines.

One of the most effective public health strategies ever adopted in the United States has been to mandate that children entering school show proof of having received recommended vaccines. Since almost every child attends school, this policy, if enforced, ensures that all children will receive the recommended vaccinations. The Department of Health, in collaboration with the D.C. Public Schools, undertook a campaign to improve child immunization rates in early 2002. This involved computerizing immunization histories so as to be better able to identify children who are lacking recommended vaccinations and taking steps to improve compliance at the individual and community level through a mass vaccination campaign.

The general DC Healthy People 2010 goals regarding Immunization of children in the District are the following:

Goal 17-1: Primary Immunization levels in Children 19-35 months of age in the District are 90% or higher.

Goal 17-3: Immunization coverage rate of 95% has been maintained in the District for children in licensed childcare facilities, Head Start, and Prekindergarten classes.

Goal 17-5: Immunization levels for children in grades kindergarten, first and fifth for each of the antigen, including hepatitis and Varicella in the District are at 98%.

B. Vaccination for Adult Conditions
In comparison to childhood immunization practices, no local legislation exists to govern adult immunizations. Programs to enhance these immunizations generally depend on increasing provider awareness and public interest in immunization through media campaigns and immunization drives.

In some cases, programs may target a special population that is at high risk, that is, outreach to intravenous drug users, persons with multiple sex partners and health care workers to offer vaccination for Hepatitis B. Hepatitis B, a chronic viral infection of the liver that causes liver failure in a high proportion of those infected, and liver cancer in some, is transmitted from person to person through intimate contact or sharing of body fluids.

There is no reliable cure for Hepatitis B, though some people are helped by a combination of anti-viral drugs administered over a long period of time. However, Hepatitis B can be effectively prevented through vaccination. Since 1991, the United States has recommended vaccination of infants for Hepatitis B, along with catch-up vaccination of adolescents born before 1991, and vaccination of high-risk adults (those likely to be exposed to contaminated body fluids, including intravenous drug users, persons with multiple sex partners and health care workers).

Another example of a targeted program is for Pneumonia, the 7th leading cause of death in the District of Columbia in 2000 when counted with Influenza. Many cases of pneumonia are caused by the pneumococcus bacterium and by the influenza virus. Infection with both of these organisms can be prevented through vaccination. Pneumococcal vaccine is administered every ten years to those at risk, and influenza vaccine annually. At present, these vaccines are recommended principally for those over age 64.

Tetanus vaccination is recommended every ten years throughout the lifespan. Tetanus vaccination is generally managed by treating physicians.

DC Healthy People 2010 Goals concerning adult immunizations are as follows:

Goal 17-8: Adult Immunization rates for influenza coverage for high-risk individuals have been increased and sustained in the District at 90% for non-institutionalized adults 65 years of age. (AIP, 2002)

Goal 17-9: Adult Immunization rates for pneumococcal vaccine coverage for high-risk individuals have been increased and sustained in the District at 60% for non-institutionalized adults 65 years of age.

3.Oral Health

To date, health promotion and disease prevention activities regarding oral health in the District have been limited (DOH, 2001). The lack of affordable dental care is considered by many to be an area of concern in the District - Less than 25 percent of the nearly 81,000 beneficiaries eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) received any dental service during the most recent reporting period, and only 17 percent received some preventive services. For those ages 6 to 9 years, less than 30 percent received any dental service in FY2001.

The low rate of Medicaid reimbursement to dental providers has often been cited as the primary factor in the underutilization of services. Reportedly 93 percent of practicing dentists in the District do not accept Medicaid patients. In FY2001, the Medical Assistance Administration conducted an internal review of all provider rates, and developed options for future rate increases for dentists in order to address this important health issue.

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The Department of Health has undertaken several initiatives to assist in the creation and implementation of an oral health program. For example, in May 2001, the DOH submitted a request to the Centers for Disease Control (CDC) for funding to create coalitions and networks of partners for oral health and improve access to quality services. Support from DOH will be used to initiate an oral health surveillance system; develop effective regulations, standards and guidelines; inform policy makers and the public; strengthen community participation a school based dental sealant program.

4. Nutrition and Exercise

(Nutrition and Overweight: DC Healthy People 2010 Chapter 1; federal *Healthy People* 2010 Chapter 19)

The role of nutrition and diet in promoting health and reducing incidence of chronic disease for conditions such as diabetes and cardiovascular disease has been well documented. In addition, according to the CDC, at least one-third of all cancers are attributable to poor diet, physical inactivity, and overweight. (Dileep G. Bal, MD, MS, MPH. President, American Cancer Society)

In light of these findings and the high rates of these diseases in the District, disease prevention efforts must include strong programs for healthy eating and physical activity. These programs will help reduce the incidence of many chronic diseases and will effectively improve health outcomes and help prevent or halt progression of full-blown chronic disease and thus decrease chronic disease disability.

It is likely that expanding health promotion and disease prevention programs that target dietary change and encourage an active lifestyle among residents of the District of Columbia could save a substantial amount of health care resources and enhance health status of the population.

In order to expand initiatives in nutritional education, training programs that involve both theory and practice for health care professionals need to be carried out. In nutrition, primary prevention activities include:

1. Nutrition classes for adults;
2. Environmental changes to provide healthy food choices in schools and public worksite cafeterias; and
3. Health campaigns and fairs to promote fruits and vegetables and other healthful foods.

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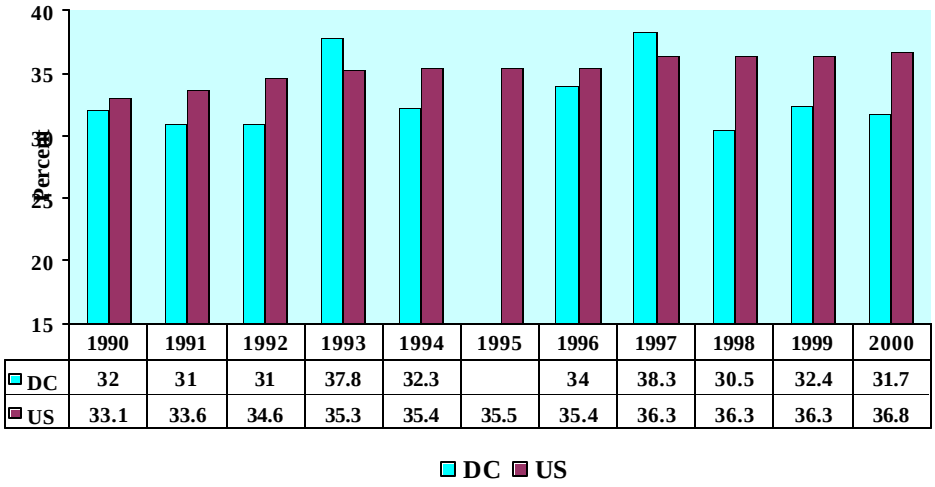
Secondary nutrition interventions include efforts to assess and reduce risk, including one-on-one or group nutrition counseling programs for at risk groups; cholesterol screening for those with a genetic predisposition for cardiovascular disease, and diabetes education programs for high risk groups.

The District of Columbia is experiencing an unprecedented epidemic of obesity and type II diabetes. Figure 1 illustrates the percentage of overweight D.C. residents and the U.S. One in three adult residents of the District is obese (source) and, therefore, at higher risk of heart disease, diabetes, stroke, high blood pressure, and other diseases. Obesity rates in children have doubled over the last two decades. Physical inactivity and unhealthy eating are major contributors to disabilities such as loss of independence due to stroke and osteoporosis-related hip fractures, and amputations and blindness that result from diabetes (***Obesity, Diabetes, and Other Diet- and Inactivity- Related Diseases in the District of Columbia.*** Center for Science in the Public Interest, 1998).

Figure 1. Overweight: By Body Mass Index for District of Columbia vs. United States



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
DC	32	31	31	37.8	32.3		34	38.3	30.5	32.4	31.7
US	33.1	33.6	34.6	35.3	35.4	35.5	35.4	36.3	36.3	36.3	36.8

Note: No data available for DC in 1995
Source:

According to the Centers for Disease Control and Prevention (CDC), unhealthy eating and physical inactivity play contributing roles in the causes of death in the District. Unhealthy eating and physical inactivity cause many serious and life-threatening diseases, including heart disease, cancer, stroke, high blood pressure, obesity, diabetes, and osteoporosis.

Many of these premature deaths could be prevented through physical activity and good nutrition.

The CDC (in *Chronic Diseases and Their Risk Factors: The Nations Leading Causes of Death,* 1999) estimates that 80% of District residents are at risk for health problems due to a lack of physical activity. If inactive individuals in the District became more active, the health care costs savings would be approximately $198 million a year (equal to 64% of the District's FY 2001 appropriation to the DC Department of Health).

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The District of Columbia's Department of Health Bureau of Chronic Disease Control has a Physical Activity Program (made up from the infrastructure of the Cancer Control, Cardiovascular Disease, and Diabetes Programs), which will provide the means to motivate behavioral and cultural changes among District residents towards physical activity to prevent and reduce the high burden of chronic disease. The program's plans are to improve the overall wellness of District residents by increasing the number of youth and adults that participate in fitness activities in schools, sporting activities, and everyday recreational activities, as well as to better understand the benefits of an overall healthy lifestyle. Through these activities, the program will contribute to citywide efforts to help reduce the prevalence of obesity and other etiologic factors for chronic disease that disproportionately affect District residents.

Regular physical activity improves health in the following ways:

1. Reduces the risk of dying prematurely;
2. Reduces the risk of dying prematurely from heart disease;
3. Reduces the risk of developing diabetes;
4. Reduces the risk of developing high blood pressure;
5. Helps reduce blood pressure in people who already have high blood pressure;
6. Reduces the risk of developing colon cancer;
7. Reduces feelings of depression and anxiety;
8. Helps control weight;
9. Helps build and maintain healthy bones, muscles, and joints;
10. Helps older adults become stronger and better able to move about without falling;
11. Promotes psychological 'well-being'.

Proposed activities to reduce the high prevalence of obesity in the District include after-school fitness programs, an annual Inner-City Games, City-Wide Fitness Challenge, physical education demonstration projects, and work-site fitness programs. Through these activities and additional evidence-based interventions, the Physical Activity Program seeks to lower the rates in obesity, cancer, cardiovascular disease, diabetes, and increase the number of District resident that participate in physical activity.

The goals on the Nutrition chapter of the DC healthy People 2010 were updated for the Annual Implementation Plan of 2002, and read as follows:

Goal 1-1: The proportion of infants and Children up to five years of age in the Women, Infants and Children (WIC) Program with a hemoglobin of 11.5gm/dl or less as registered at subsequent certification visits has been reduced by 4 percent. (AIP, 2002)

Goal 1-2: The rates for breast-feeding and the duration of breast feeding among women enrolled in the WIC Program in the District of Columbia have been increased to 35%. (AIP, 2002)

Goal 1-3: Seventy-five percent of WIC participants presenting for a second nutrition contact are taught about the health hazards of obesity and he benefits of good nutrition and regular exercise

as life-long prevention strategies in a section on obesity in the core WIC Education Curriculum. (AIP, 2002)

C. Prevention and Management of Specific Conditions

The District's approach to disease prevention and management begins with an assessment of the determinants of each disease, including behavioral risk and lifestyle as well as environmental factors. Most of the problems associated with chronic disease can be managed through the following steps:

1. Enhancing awareness of behavioral and environmental risk factors and lifestyle decisions at the individual and population levels;
2. Encouraging and supporting behavior change to reduce the risk to individuals of contracting and/or transmitting the condition;
3. Promoting early diagnosis through screening for the disease;
4. Increasing access to treatment;
5. Increasing access to appropriate support services including proper case management;
6. Promulgation of clinical guidelines and protocols for treatment and disease management; and
7. Epidemiological tracking of the disease in the population.

The Department of Health is continuing to enhance its comprehensive strategies to prevent and manage key chronic and communicable diseases including:

1. Asthma
2. Cancer
3. Cardiovascular disease
4. Diabetes
5. HIV/AIDS
6. Substance Abuse
7. Sexually Transmitted Diseases
8. Tuberculosis

The chronic diseases and other conditions in Table 2 have been addressed in the District's Healthy People 2010 similarly as specific focus areas where prevention and reduction of disease and elimination of racial and ethnic disparities are stated goals.

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Table 2. Ten Leading Causes of Death in DC, 2000

Cause	Number of deaths per year*	Percent preventable through healthy eating and physical activity** (1998)	Diet- and inactivity- related deaths per year (1998)
1. Heart Disease	1,566	16 – 30%	350
2. Cancer	1,329	35 %	472
3. Hypertension	236	--	--
4. CVD (Stroke)	226	23 – 39 %	94
5. HIV/AIDS	225		
6. Accidents	213	--	--
7. Influenza & Pneumonia	204	--	--
8. Diabetes	196	80 %	156
9. Assaults (Homicide)	174	--	--
10. Chronic Lower Respiratory Disease	167	--	--
Total	4,536	--	1,072

*DC Department of Health, State Center for Health Statistics Administration

**McGinnis JM, Foege WH, Actual Cases of Death in the United States, JAMA. 1993:270:2207

1. Asthma

Asthma is a significant cause of morbidity in the District. Utilization of the District emergency rooms as a primary source of asthma care is widespread especially for residents in Wards 6, 7, and 8.

Asthma, among children under the age of fifteen, is the number one cause of hospitalizations for this age-group in the District of Columbia. In the District in 1998, there were 998 pediatric asthma discharges (D.C. Hospital Association, 2000). In 2000, the number of asthma cases was 1,705 and the prevalence rate was 8.0%. The national figures by comparison were 181,194 cases representing a prevalence rate of 7.25.

Indicators of asthma burden in children such as days absent from school, percentage of children under 18 years reporting asthma, and percentage of children reporting limitation of activity resulting from chronic conditions, all show that areas of the city with limited access to care, high rates of poverty, and inadequate nutrition overlap with areas of high asthma burden.

The DOH has identified asthma as an important special need for children and as such has incorporated asthma education including knowledge of triggers, self-management of

disease, and use of medication in the school-based health curriculum. Partnerships in asthma education via Open-Airways administered by the American Lung Association of DC, "Room to Breathe" initiative, and Asthma Care Training (ACT) have been formed. The Administration also supports an annual asthma camp for children in conjunction with the American Lung Association of DC.

Adult asthma education is being addressed through programs for families with asthmatic children and through provider education and participation in area Health Maintenance Organizations' disease management programs. The DOH will explore collaboration with professional societies and healthcare organizations to ensure increased adherence to published guidelines for management.

2. Cancer

The District ranks first among all states in breast and cervical cancer mortality.

Early detection of breast cancer is critical for all residents of the District, but it is particularly important for African American women because they have the highest mortality and lowest survival rates. Strategies for reducing mortality associated with breast and cervical cancer involve the improvement of early detection by providing screening services to women without health insurance in readily accessible clinical settings. The current approach is to continue to increase the number of screening sites in the WISH network and to continue to increase the total number of preventive health screenings every year. Figure 2 shows the age-adjusted death rate by race for all cancers in the District and the United States.

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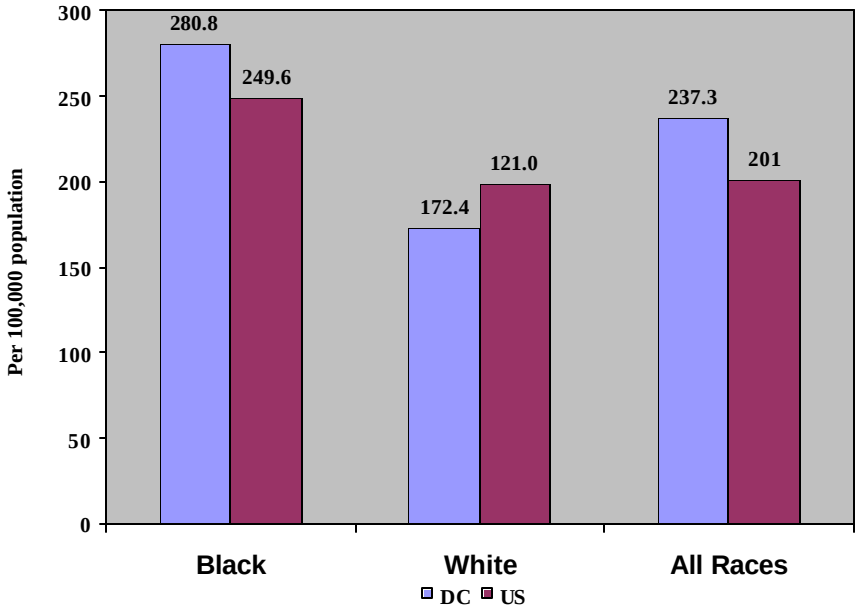
Figure 2. Age-Adjusted Cancer Death Rate by Race: District of Columbia and United States - 2000



Source: DC Department of Health, State Center for Health Statistics Administration
US Department of Health and Human Services, National Center for Health Statistics

3. Cardiovascular Diseases

Cardiovascular disease is the leading cause of mortality in the District as it is nationally.

Major cardiovascular diseases category is comprised of five main sub-categories: Diseases of the heart, essential (primary) hypertension and hypertensive renal disease, cerebrovascular diseases, atherosclerosis, and other diseases of circulatory system. In 2000, heart disease is the leading cause of death both in the District and the United States. Essential (primary) hypertension is the third leading cause of death followed by cerebrovascular diseases (stroke), which is ranked 4th. Atherosclerosis ranked 14th in the District of Columbia. Profound racial and ethnic disparities in the burden of cardiovascular conditions exist especially in the areas of secondary and tertiary disease prevention utilization. Overall the black-white differences for all major cardiovascular mortality were 471.6 and 279.2 per 100,000 residents respectively, representing a 69 percent higher mortality for black residents in 2000. Figure 3 specifically shows the age-adjusted rate due to heart disease by race for the District and United States.

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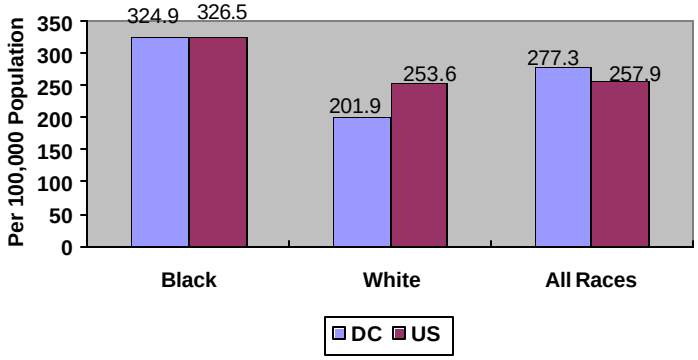
Figure 3. Age-Adjusted Heart Disease Death Rate by Race: District of Columbia and United States – 2000



Source: DC Department of Health, State Center for Health Statistics Administration
US Department of Health and Human Services, National Center for Health Statistics

In its current activities for heart health the DOH collaborates with national and local organizations such as the American Heart Association, the CVS Connection, Chartered Health, and the Washington Hospital Center for dissemination of primary and secondary prevention messages. High blood pressure, cholesterol, and diet are among the issues addressed in brochures, announcements, health fairs, and screening events.

In 2001 the DOH received a grant from the CDC to establish a core program in cardiovascular disease. This program will foster collaborations between the various private, non-profit agencies, government agencies, health care organizations, and community groups, to provide input and guidance for a state plan to reduce the burden of cardiovascular disease.

4. Diabetes

Diabetes is the eighth leading cause of mortality in the District.

Diabetes fell from its 1999 rank as the sixth leading cause of death in the District to the eight leading cause of death in 2000. The death rate for diabetes in the District was the second highest in the nation and significant racial disparities exist in diabetes incidence, death rate, and complications rates for black compared to white residents. The prevalence rate has risen from 5.6 percent in 1996 to 6.5 percent in 1999. Risk factors for developing diabetes including obesity, family history, and high blood pressure have an extremely high prevalence among District residents and particularly African Americans, Hispanics, and Asian Americans in the District.

In the District of Columbia, diabetes accounted for 34.9 deaths per 100,000 population in 2000 (age-adjusted), compared to 25.2 per 100,000 nationally (DC

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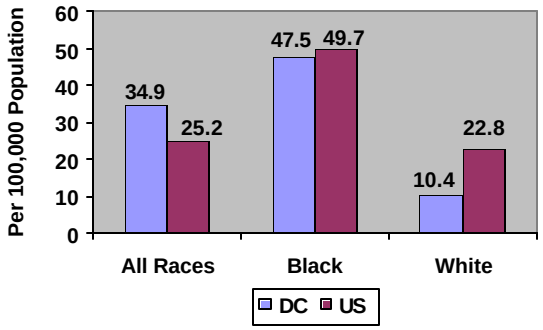
State Center for Health Statistics, 2002; US National Center for Health Statistics, 2002).

Data for 2000 (Figure 4) show higher mortality rate for blacks (age-adjusted mortality rate, 47.5 per 100,000) than whites (age-adjusted mortality rate, 10.4 per 100,000) in the District of Columbia. Adult African Americans are 1.7 times as likely to have diabetes as non-Hispanic whites; Mexican Americans and other Latinos are almost twice as likely to have the disease, and American Indians and Alaska Natives are 2.8 times as likely (CDC Diabetes Factsheet, 1998). From 1996 through 2000, the mortality rate from diabetes was the lowest in 1997 and then rose again in 1998 and 1999 (Figure 5).

Figure 4. Age-adjusted Death Rate for Diabetes by Race: United States and District of Columbia, 2000



Source: DC Department of Health, State Center for Health Statistics Administration, 2002.
US Health and Human Services, National Center for Health Statistics, 2002

Current literature supports the notion that diabetes is a risk factor for heart disease, stroke, high blood pressure, and kidney disease, as well as nervous system impairment and periodontal disease. It also may compromise an individual's quality of life and contribute to several other primary causes of death. Diabetes is also the primary cause of new cases of blindness in adults 20 to 74 years of age, and more than half of amputations of the lower limbs in the U.S. are a result of diabetes.

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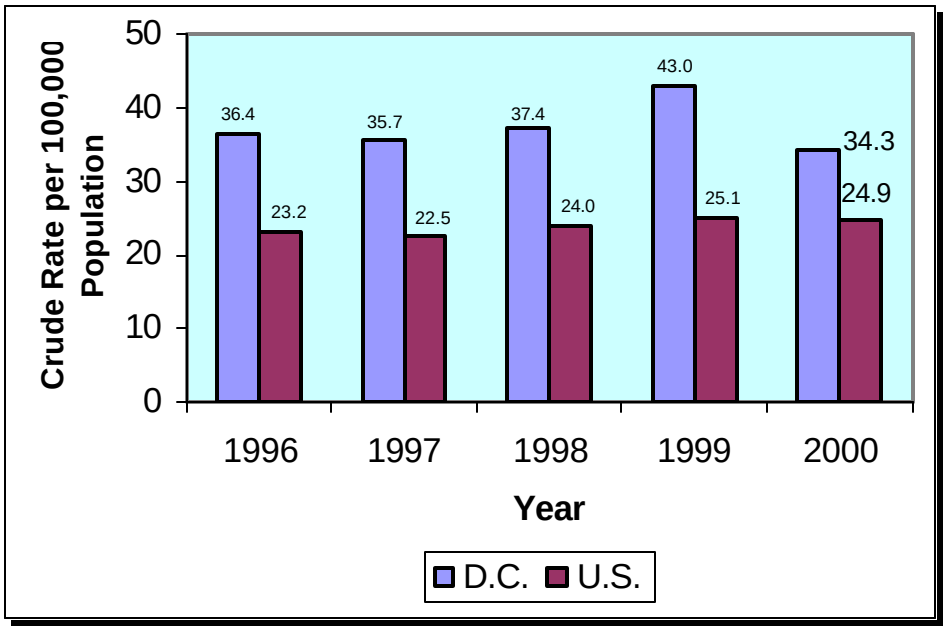
Figure 5. Diabetes as Cause of Death in the District and US 1996-2000



Source: DC Department of Health, State Center for Health Statistics Administration, 2002.
US Health and Human Services, National Center for Health Statistics, 2002

5. HIV/AIDS

The number of persons newly diagnosed with AIDS has been declining, as well as the number of deaths attributed to HIV/AIDS.

However, the number of individuals with AIDS remains disproportionately higher in the District than in most other cities in the United States. In 2000, the AIDS case rate for the District was 152.9 per 100,000 people population compared to the 14.6 per 100,000 people for the United States as a whole. Major changes in national AIDS trends have taken place due to changes in the patterns of HIV transmission.

HIV/AIDS is the fifth leading cause of death in the District in 2000. Figure 6 shows the age-adjusted HIV/AIDS death rate by race and Figure 7 shows the death rate by HIV/AIDS by gender of D.C. residents in 2000.

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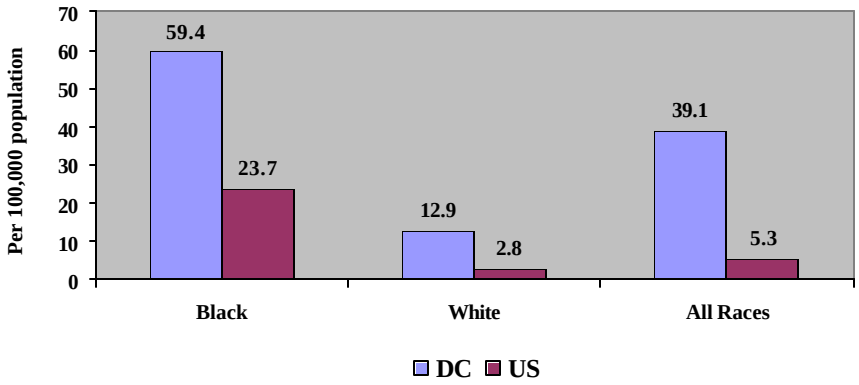
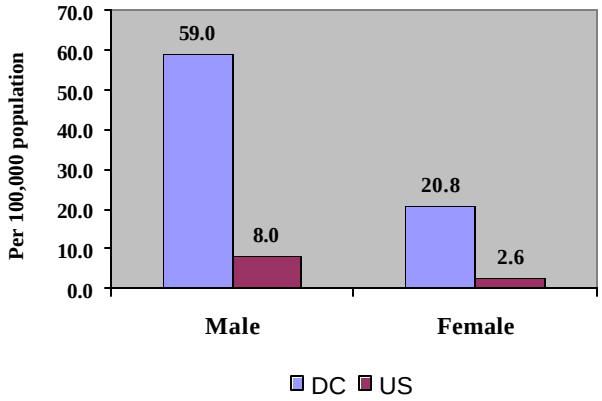
Figure 6. Age-Adjusted HIV/AIDS Death Rate by Race: District of Columbia and United States - 2000



Source: DC Department of Health, State Center for Health Statistics Administration, 2002
US Health and Human Services, National Center for Health Statistics, 2002

Figure 7. Age-Adjusted HIV/AIDS Death Rate by Gender: District of Columbia - 2000



Source: DC Department of Health, State Center for Health Statistics Administration, 2002
US Health and Human Services, National Center for Health Statistics, 2002

Data on new AIDS cases show a continued shift within the total number of people with AIDS to a larger proportion being comprised of persons of color, women, and injection drug users. Among males, diagnosed AIDS cases peaked in 1993 – the year that CDC expanded the definition of AIDS. Among females the peak was not reached until 1998.

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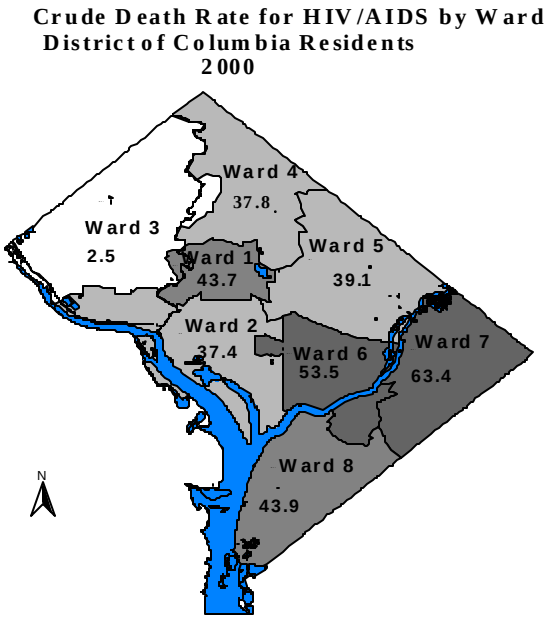
Additionally, AIDS transmission through heterosexual contact also continues to increase. At the end of 1999, of the number of AIDS cases, Black or African –Americans represented 75 percent of the cases, Whites represented 21 percent of the cases and Hispanics 3 percent of the cases. During 1999, more African Americans living in the District were diagnosed with AIDS than in 1990 (The Mayor's 2001/2002 Policy Book). In 2000, the following map captures the concentration of deaths by ward of individuals diagnosed with HIV/AIDS.



The D. C. Department of Health is committed to improving access to care and enhancing the quality of life of all its residents with HIV/AIDS. Through integrated services that will ensure early access to needed life-saving interventions for 2002 and beyond, DOH will focus on meeting the needs of those recently diagnosed.

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Enhancement of HIV/AIDS services can be generally grouped under nine interrelated areas of service:

- Development of a unique identifier system for tracking of HIV infection;
- Testing and counseling performed at sites throughout the city;
- Surveillance and seroprevalence studies;
- Outreach and prevention activities, including distribution of condoms and patient education in places frequented by persons at risk of HIV/AIDS;
- Emergency relief and other essential services to individuals with HIV and their families;
- Long-term housing strategies for persons living with AIDS;
- Partnerships between DOH and community-based organizations providing HIV/AIDS prevention and intervention services;
- Substance abuse services focusing on patients at risk of HIV/AIDS;
- Improved quality, availability, and organization of health care and support services for persons with HIV/AIDS.

All of these strategies promote health and prevent disease among patients at risk of HIV and those who have contracted the disease. District residents at risk of HIV—substance abusers, prisoners, the homeless, men who have sex with men, and other vulnerable populations—require outreach, education and condom distribution to curb the spread of this devastating illness. People with HIV/AIDS require access to a continuum of care from the point of diagnosis.

Adequate nutrition, primary care, and access to triple therapies can forestall the progress of HIV to AIDS when, by definition, one or more opportunistic infections such as pneumocystis carinii and Kaposi's sarcoma are present. As the disease progresses, access to parenteral therapy, bronchoscopy, dermatology, neuropsychiatry, and ophthalmology, among other medical subspecialties, is crucial to maintaining health and mitigating the impact of various disease processes.

Both patients with HIV/AIDS and their families also require intensive support service to maximize patient longevity and quality of life, including individual and group counseling, social work and case management services, legal and housing assistance, drug assistance, transportation, translation, and respite care. Ensuring the accessibility and availability of this continuum of medical and psychosocial services is the global health promotion/disease prevention strategy employed by the District's HIV/AIDS Administration.

6. Sexually Transmitted Disease (STDs)

The three predominant sexually transmitted diseases (STDs) in the District (apart from

HIV) are gonorrhea, syphilis and chlamydia. All are highly transmissible through sexual contact. All can cause serious complications if untreated, including pelvic inflammatory disease, miscarriage, infertility, blindness and various other medical conditions. STDs are a result of unsafe sexual practices that also place patients at risk of other undesirable outcomes, such as unwanted pregnancy and HIV infection.

Although District Gonorrhea and Syphilis rates have been declining steadily since 1990, the rates remain higher than those for comparable cities. Among cities with a population over 200,000, DC ranks 6th in gonorrhea case rate, and 14th in syphilis case rate. Reported cases of chlamydia rose dramatically in the mid-1990s in the city.

According to D.C. Health People 2010, the incidence of gonorrhea among District residents in 1997 was 823 per 100,000 residents, almost seven times the 122.5 cases per 100,000 population in the U.S. The rate among adolescents was 258.6 per 100,000 (DOH,2000). The incidence of syphilis was 20.4 per 100,000 compared to 17.4 per 100,000 nationally (HRSA,1998), resulting in a congenital syphilis rate of 133 per 100,000 live births.

Chlamydia may go undetected for a long period, especially in women, in whom it can cause few or no immediate symptoms (though over time, infection often leads to genital scarring and infertility). Thus, many infected women and men are long-term, infectious carriers. With the advent of a widespread chlamydia-screening program in the District, chlamydia rates have started to decrease in the past two years (Source: D.C. State Center for Health Statistics Administration).

The standard model of population STD control has three components:

- Reduce the duration of infectiousness of any individual with a treatable STD, through early diagnosis and treatment;
- Reduce the risk of transmission of STDs from infected to non-infected individuals, by promoting the widespread use of barrier methods of contraception; and
- Reduce the number of new infections caused by an individual carrying an STD, by reducing the number of sexual partners of that individual.

The District's STD control program is funded by an ongoing grant from the CDC, supplemented by local funds. The majority of the program staff is made up of CDC assignees. The STD Clinic, located on the grounds of the former D.C. General Hospital campus, is the core of the District's service delivery mechanism—50 percent of all reported cases of STDs in the District are treated there. The clinic provides confidential diagnosis and treatment to patients who present with symptoms of STDs. Patients are seen on a walk-in, first-come-first-served basis.

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The STD control program also has a partner notification service. Individuals diagnosed with STDs are asked to identify all recent sexual partners. These partners are then contacted and notified that they may have been exposed to an STD. The identity of the source case remains anonymous. Contacted individuals have shown a high rate of compliance with recommended screening and treatment. All STDs diagnosed in the District are required to be reported to the DOH. Patients diagnosed with STDs at sites other than the STD clinic are contacted to initiate a partner notification process. Contact tracing and partner notification is undertaken for 90 percent of all diagnosed STDs in the District.

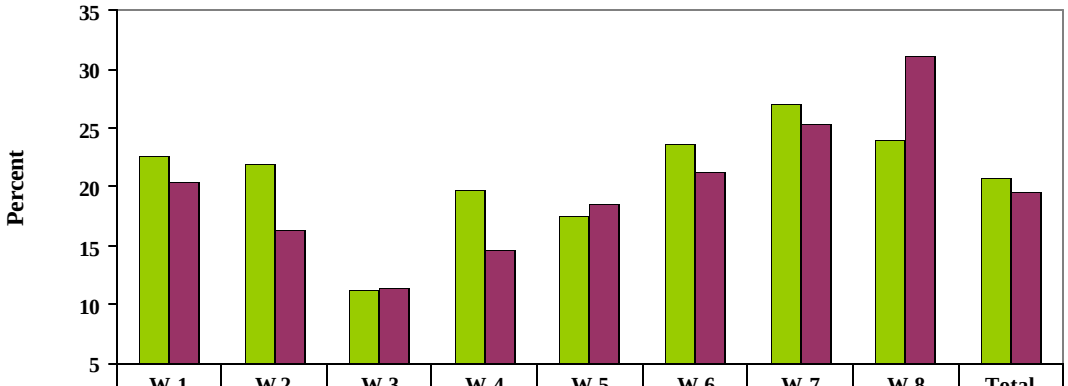
STD Clinic services and partner notification support the first component of the model described above, "reducing the duration of infectiousness of any individual with a treatable STD, through early diagnosis and treatment". The STD Program also addresses the other two components of the model by providing patient counseling that discourages multi-partners and the use of barrier methods, and by free condom distribution.

7. Substance Abuse

(DC Healthy People 2010 Chapter 20; *Healthy People* 2010 Chapter 26)

The District of Columbia is committed to preventing the use of alcohol, tobacco, and other drugs (ATOD) through effective substance abuse prevention strategies including education and information, alternative activities, community-based and environmental strategies, and early intervention. Children and youth are the primary targets of prevention interventions; however, intervention and referrals are appropriate for all of the citizens of the District of Columbia. Figure 9 illustrates the prevalence of cigarette smoking in the District by Ward.

Figure 9. Current Cigarette Smoker by Ward (Adults 18 and Older) 1996 and 2000



	W 1	W 2	W 3	W 4	W 5	W 6	W 7	W 8	Total
1996	22.6	22	11.3	19.8	17.6	23.6	27	24	20.7
2000	20.5	16.4	11.4	14.7	18.6	21.3	25.4	31.2	19.5

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Note: W= Ward
U.S. Rates - Current smokers (Adults 18 and older) in 1996, 1997, 1998, 1999, and 2000 were, 23.4%, 23.2%, 22.9%, 22.6%, and 23.2% respectively.
%= Weighted prevalence analyzed using SUDAAN software
Current cigarette smoker = adults 18 years and older who have smoked at least 100 cigarettes in their lifetime and now smoke
Source: District of Columbia Department of Health,
Bureau of Epidemiology and Health Risk Assessment,
BRFSS Survey

Primary prevention services will be provided for youth and adults, including seniors, who are at risk for alcohol, tobacco and other drug abuse but who may not need treatment services. More specifically, the service population will include all residents of the District of Columbia:

- The general population inclusive of youth, adults, seniors, who are at-risk and/or high-risk for alcohol, tobacco, and other drug-related problem (ATOD);
- Families and friends of persons at-risk for an ATOD problem;
- School students and school officials;
- Community groups mobilizing to combat ATOD abuse, including civic and volunteer organizations;
- Churches and businesses;
- District-related community organizations; and
- District of Columbia government employees and employers of persons at risk for alcohol, tobacco and other drug problem.

The Office of Prevention and Youth Services utilizes the six methods and approaches used to meet the Substance Abuse Prevention and Treatment (SAPT) block grant requirements for primary prevention funding to address the needs of these special populations. The Center for Substance Abuse (CSAP) proposes six strategies that include: Information Dissemination, Prevention Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental Approach. Examples of activities conducted and methods used to implement each strategy, as well as a definition of each strategy are provided in the following sections.

a. Information Dissemination Strategy
Information dissemination services include activities that provide awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug use, abuse and addiction, and their effects on individuals, families and communities. These services also provide knowledge and awareness of available prevention programs and services. Information dissemination is characterized as a universal strategy applicable to all regardless of the level of ATOD involvement. Examples of activities conducted and methods used for this strategy are: clearinghouse/information resource center(s); resource directories; media campaigns; brochures, pamphlets posters, and newsletters; radio/TV public service announcements; speaking engagements; health fairs/health promotion; and information and referral services.

b. Prevention Education Strategy
ATOD prevention education involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator and/or facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis, and systematic judgment abilities. Examples of activities conducted and methods used for this strategy include, but are not limited to the following: classroom and/or small group sessions (all ages); parenting and family management classes; peer leader/helper programs; education programs for youth groups; children of substance abuser groups; and, education programs for adults and senior groups.

c. Alternatives Activities Strategy
Alternatives activities provide for the participation of target populations in activities that do not include alcohol, tobacco and other drug use. The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs. Examples of activities conducted and methods used for this strategy include, but are not limited to: community service projects (all ages); youth/adult leadership activities; after-school programs; community drop-in centers, and alcohol and drug free parties and social events.

d. Problem Identification and Referral
Problem identification and referrals identify those who have indulged in illegal/age inappropriate use of tobacco or alcohol and those who have indulged in early use of illicit drugs, in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include, but are not limited to: employee assistance programs; student assistance programs; supervisory training for alcohol and drug testing of District employees holding commercial driver's licenses.

e. Community-Based Process Strategy
The community-based process enhances the ability of the community to more effectively provide prevention and treatment services for ATOD abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services, implementing inter-agency collaboration, coalition building and networking. Examples of activities conducted and methods used for this strategy include, but are not limited to: assessing community needs and risk and protective factors; community and volunteer training such as neighborhood action training, training of key people in the system, staff/officials training; and systematic planning multi-agency coordination and collaboration; accessing services and funding.

f. Environmental Approach

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The environmental approach strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives, and those that relate to the service and action-oriented initiatives.

Examples of activities conducted and methods used for this strategy shall include but are not limited to:

- Promoting the establishment and review of comprehensive alcohol, tobacco and drug use policies in individual community organizations such as schools, businesses and others;
- Providing technical assistance to communities to maximize local enforcement procedures; governing availability and distribution of alcohol, tobacco and other drugs; and
- Modifying alcohol and tobacco advertising programs.

g. Secondary Prevention Services

Secondary prevention services, or early intervention as it is commonly referred, are intended to work with youth and adults, inclusive of seniors, who display multiple risk factors relevant to alcohol, tobacco, and other drug use, abuse and dependency. Specific services are intended to intervene with or divert individuals involved with experimentation or use of legal or illegal substances. Services to be provided include, but are not limited to, brief interventions, support groups, and diversionary programs.

The service population includes, but is not limited to: youth and adults, including seniors, who display multiple risk factors relative to an ATOD problem; youth and adults who may be children of substance abusers; intergenerational substance abuser; services may also be provided to the general population, families and friends of persons at high risk for a ATOD problem; school students and school officials; community groups mobilizing to combat alcohol, tobacco and other drug dependency, including civic and volunteer organizations, churches and businesses; District of Columbia related community organizations; District of Columbia government employees and employers of persons at risk for an alcohol, tobacco and other drug problems.

Another key prevention activity led by DOH is the operation of two programs targeted specifically to teens, including the Safe and Drug-Free Schools program and the State Incentive Grant. The first initiative supports DOH programs to make schools free of drugs violence and the unauthorized presence of firearms and alcohol. The initiative has been designed to coordinate all substance abuse prevention resources in the context of a comprehensive and effective strategy to reduce marijuana and other drug use among the District's youth. In addition to the D.C. Youth Movement Against Tobacco Use program, DOH is coordinating substance abuse efforts with other DOH programs intended to discourage smoking and other tobacco use among teens.

The goals in the DC Healthy People 2010 Plan related to users of cigarette smoking. Alcohol and marihuana are the following:

Goal 20-1: No more than 50% of youth report ever having tried cigarette smoking.

Goal 20-2: No more than 51% of youth report ever having drunk alcohol.

Goal 20-3: No more than 20% of youth report ever having used marihuana.

8. Tuberculosis (TB)

Tuberculosis (TB) remains an important public health problem in the District of Columbia despite a decline in the number and rate of new cases seen yearly (1998: 107 new cases, 1999: 70 new cases and 2000: 85 new cases). The 85 new cases of tuberculosis in 2000 indicate a case rate of 14.9 per 100,000 residents. While the overall rates are declining, the percent of cases occurring in foreign-born persons has increased over the last five years to approximately 30 percent in 1999 and 2000 and 34 percent in 2001. Many of the foreign-born TB patients are from Africa, Asia and Central and South America. Multi-drug resistant cases, an indicator of the program's effectiveness in obtaining patient adherence to treatment, have remained low at 2 percent according to recent studies by the Centers for Disease Control (CDC).

The decline in the District from 20.5 cases per 100,000 to 13.5 cases per 100,000 population has improved the 1999 Centers for Disease Control's ranking to second in the nation. This may be due to various intervention programs by the District's TB Control program. Despite these improvements, TB has generally undergone a resurgence in the U.S. and over the years multiple-drug resistant strains of TB have emerged. As a result, TB continues to be a major challenge to the District, hence a focus area for a concerted and targeted approach.

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Table 3. State-Specific Tuberculosis Case Rates, 1996-2000

(Cases per 100,000 population)

RANK (in the nation)	STATE	RATE	# OF CASES	YEAR
	DC	14.9	89	2000
2	DC	13.5	70	1999
19	MD	5.7	294	1999
24	VA	4.9	334	1999
1	DC	20.5	107	1998
20	MD	6.5	324	1998
23	VA	5.0	339	1998
1	DC	20.8	110	1997
17	MD	6.7	340	1997
24	VA	5.2	350	1997
1	DC	25.6	139	1996
21	MD	6.3	319	1996
26	VA	5.2	349	1996

Source: CDC 2000.

The Bureau of Tuberculosis Control performs diagnostic and free treatment services for residents with active tuberculosis. The Bureau also serves those contacts of active cases providing identification and treatment for those persons infected but not active cases. All cases are managed by nurse case-managers and outreach staff that provides Directly Observed Therapy (DOT) to 80 percent of cases. Diagnostic services for high-risk residents e.g. HIV/AIDS, substance abuse, and nursing home entrants, are coordinated through the Bureau.

II. PROMOTING HEALTHY CHOICES AND PRACTICES

Health promotion strives to prevent disease by interfering with either its initial appearance or intervening to avoid progression of the disease. Health promotion seeks to examine risk factors and develop integrated public health messages through social marketing and communication strategies designed to promotion healthy lifestyles. Through behavioral change messages, health promotion strategies seek to communicate key disease prevention information to the public.

Various health promotion strategies exist and are under development in the District to target population groups by lifecycle, gender, and race and ethnicity. Each of the steps articulated above includes a tailored approach for each of the following interventions:

- Mass media
- Development of Materials
- Educational Activities
- Individual Counseling/Service Delivery

A. Health Promotion for All Ages

1.Perinatal/Pediatric Lifecycle Initiatives

A number of local initiatives are targeted toward reducing infant mortality and improving infant and child health through key activities in health promotion and disease prevention including: outreach, case identification, case management, early intervention, parent education, school health and nursing initiatives, social services, and provision of essential medical services and supplemental foods. An overview of some of the city's initiatives and programs is provided below.

a. Healthy Start and Nutrition Programs

The D.C. Healthy Start Program, comprised of two federally funded health promotion projects, including one in Wards 5, 6, 7, and 8. They have been designed to reduce infant mortality and reduce some of the health disparities between African American women of reproductive age and women from other racial and ethnic groups. It is hoped that this strategy will improve peri-natal and pediatric health. Although originally initiated as a demonstration project in 1992, the District's Healthy Start program was immediately successful in increasing participation in prenatal care and reducing negative health outcomes, including low birth-weight. On the basis of these positive outcomes, the project was refunded and expanded through 2005.

The three core promotion/prevention strategies of D.C. Healthy Start include outreach, case management, and health education in best practices and nutrition. These are accomplished in close collaboration with a variety of coordinated services and resources including the Title V-funded hotline used for D.C. Healthy Families (1-800 MOM-BABY), transportation for Women Infants and Children's program (WIC) food recipients, Ryan White Title IV services for HIV-infected mothers.

Under the Healthy Start Program, eligible pregnant women are sought out by dedicated outreach technicians for one-on-one counseling. Cases are located in a variety of ways from door-to-door canvassing, visits to hair and nail salons, laundries, and other business locations, and involvement in social service organizations, churches, and community events. Many clients are first reached during visits by the Maternity Obstetric Mobile (MOM) unit, a mobile curbside medical office in a van that provides pregnancy testing, fetal monitoring and risk assessment as well as health/nutrition/parenting education at social service intake offices and rotating community events and health fairs.

Healthy Start outreach technicians assist new clients with enrollment and determination of eligibility by helping to complete and submit eligibility applications to access

resources, especially prenatal care services, as early in the pregnancy as possible. Case management is the key strategy behind Healthy Start whereby pregnant clients are followed by a nurse case manager throughout the pregnancy and the perinatal period and up to 24 months after the baby's birth.

The active participation of a large community consortium helps to shape and evolve the pattern of services to better meet the needs of clients in the target population. The program also focuses on building cooperative and collaborative relationships with other agencies and programs working within the prenatal and perinatal networks of care, all of which strengthen its effectiveness as part of the District's health services safety net.

The Healthy Start Program has initiated an important collaboration with the D.C. Department of Mental Health (DMH)'s Infant Development Program to provide outpatient evaluations, psychiatric, psychological and psychotherapeutic services to pregnant women, their families and children up to age 5. The Infant Development Program's central strategies are to provide family centered early intervention and treatment in order to prevent the development of emotional and psychiatric developmental problems, and to provide social services and case management as needed to address developmental pediatric needs.

Referrals in the past have come primarily from the community childcare centers, schools, teen mother programs, child protective services, substance abuse services and primary medical care providers. In an effort to provide comprehensive disease prevention through the inclusion of psycho-social services to youngsters up to age 5, Healthy Start will work closely with PIDP to develop a referral program.

The Supplemental Nutrition Program for Women, Infants and Children (WIC) serves approximately 15,500 pregnant and lactating women, infants and children monthly and 25,000 unduplicated individuals each year. To be eligible for WIC services, an applicant must reside in the District of Columbia, have a medical or nutritional risk, and have a low-to-moderate income (i.e., less than 185% poverty).

Persons enrolled in WIC receive nutrition assessment, education, supplemental food prescriptions, immunization screening, and referrals to other health and social services and resources. In addition recipients of WIC receive nutrition counseling to ameliorate nutritional deficiencies and related health problems. WIC goals include the provision of services to an average of 17,000 women, infants and children per month and to improve the nutritional and health status for WIC recipients through the provision of high quality, interactive nutrition education and counseling services.

The Commodity Supplemental Food Program (CSFP) provides nutritious supplemental USDA commodity foods to approx 9,000 eligible pregnant and post-partum women, infants, children, and seniors 60 years and older residing in the District of Columbia. CSFP serves participants monthly through local public and private agencies. Eligible clients are provided a monthly food package containing nutrients needed for growth and

development and maintenance of good health. To be eligible for CSFP an applicant must be a District resident, categorically eligible, and have low income (less than 185% poverty for women, infants and children and less than 130% for seniors). CSFP also provides nutrition information and referrals to other health and social services resources.

The CSFP goals include the provision of services to an average of 10,391 eligible women, infants, children and seniors per month. Another goal is the improvement of the nutritional and health status of CSFP recipients through the provision of high quality nutrition information.

The Farmers' Market Nutrition Program (FMNP) provides fresh fruits and vegetables through local farmers' markets to an average of 9,000 high-risk pregnant women and children 2-5 years old, who are enrolled in the WIC Program.

b. Disability Prevention and Control

A component of the District's Disabilities Prevention and Control Program, the *Birth to Eight Project* identifies, tracks, monitors, and provides referrals for services to children enrolled in Medicaid who are at risk of or exhibit developmental delays and disabilities. Based on a prevention model, the *Birth to Eight* Project's central strategy is to focus on building the capacity to assess disability among children in this age range in order to target interventions. It also serves as a safety net to prevent these children from being lost to the service delivery system. *Birth to Eight* has a detailed computerized surveillance system that is being expanded and tailored to the needs of the District.

c. EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), the federal Medicaid comprehensive health program for individuals under age 21, provides for the early detection and treatment of disease and developmental delays.

Screening services covered under EPSDT include physical exams, immunizations, lab tests, including lead toxicity screening, health education, vision screening, dental screening, hearing services and all other necessary health care. When prescribed, eyeglasses and dental services as well as hearing aids and other prostheses are covered, as are additional diagnostic assessments and treatment of all defects and illnesses discovered during screening and diagnosis. EPSDT uses a periodicity schedule prescribing the types of screening the child should have at as an infant, preschooler, school-age child and adolescent (HCFA, 2001).

Screening requirements are based on a periodicity schedule prescribing the types and frequency of screening the child should have at specific ages and include physical exams, immunizations, vision, dental and hearing screens, developmental assessments and lead toxicity screening. Any prescribed follow up diagnostic services, specialty care, and/or treatment of diagnosed defects and conditions are provided. Given the high rate of Medicaid participation in the District of Columbia, enforcement of compliance with

EPSDT participation is a significant strategy for health promotion and disease prevention for District children and youth.

Persons enrolled in the federally funded Children's Health Insurance Program (CHIP), called DC Healthy Families, and the safety net DC Healthcare Alliance are also eligible for the same services.

d. Health Care for Children with Special Needs

The overarching goals of the Health Care for Children with Special Needs program are to improve the quality of care provided to children with special health care needs, to diminish the burden families experience in managing the numerous services their children need, and to maximize the use of scarce public health care dollars.

The District of Columbia's 1115 waiver to develop a managed care program for Medicaid-eligible, special needs children up to age 21[1] with Supplemental Security Income (SSI) coverage (DOH, 2001b), was designed to provide comprehensive and expanded coverage of medical, mental health and substance abuse services, durable medical equipment, transportation, home health services, transportation, and care coordination, as well as home visitation and other "wraparound" services. Through targeted interventions with children with serious diseases, developmental disabilities, disabling conditions, and/or serious emotional and/or behavioral problems, the program will continue to work with specialized network of physicians and specialists to improve the education of District residents surrounding the prevention of these conditions. (DOH,2001).

2.School Age Children

a. School Health Program

Four school-based teen wellness centers currently operate within District schools. They are located at: Ballou Senior High in Ward 8; Woodson Senior High School in Ward 7; Edison-Friendship Collegiate Academy in Ward 7; and Duke Ellington School in Ward 2. The centers' mission is to:

- Promote health maintenance among adolescents;
- Motivate students to adopt healthy lifestyles and avoid risk-taking behaviors;
- Provide convenient health services; and
- Teach students to appropriately and effectively use the District's healthcare delivery system.

[1] Children eligible for the program include those on SSI (about 3500), foster children in the custody of the District (about 3200), children in the custody of the Youth Services Administration, children in or at risk of residential treatment, institutionalized children who can return to a community or home setting, and children under the age of 1 with a rare and expensive diagnosis.

While the spectrum of services delivered at each center differs, all provide screening and treatment referrals, mental health support, service coordination and assistance in accessing healthcare safety net services, and health promotion.

b. School Nursing Program

The School Nursing Program is operated by Children's National Medical Center as part of its role as a member of the D.C. Health Care Alliance. This program provides a minimum of 20 hours per week of nursing coverage to the District's public schools. Where collocated, school nurses are increasingly working in coordination with the School Wellness Centers.

c. Sexual Abuse of Children

In response to the Task Force to Stop Statutory Rape sponsored by Mary's Center for Maternal and Child Care, the DOH Women's Health Initiative formed a similar work group in DOH. The purpose is twofold. The first objective of the workgroup is to research, then develop and implement protocols for reporting sexual abuse. The second is to raise awareness of the issue of sexual abuse among health care workers through the city. To this end, DOH has developed a basic flyer about the child sexual abuse laws in the District and translated the material into several languages, including Spanish and Korean. The literature will be field tested prior to community dissemination.

3. Maternal and Family Health

a. NIH-D.C. Initiative to Reduce Infant Mortality in Minority Populations

Beginning in the mid-1990s, the National Institutes of Health initiated a collaborative effort with a number of academic medical centers and providers in the District to isolate factors responsible for the high infant mortality rate in the District and initiate interventions to reduce infant mortality (NIH-D.C. Initiative to Reduce Infant Mortality, 2000). Now in Phase II, the study's present goal is to reduce the prevalence and severity of three specific risk factors linked to adverse pregnancy outcomes in African American and Latino women in the District—depression, partner abuse and cigarette smoking. Improvements in gestational age and infant birth-weight are anticipated for women in the intervention group when compared to the usual care group. Participating in the program with NIH are George Washington University Medical Center, Children's National Medical Center, Howard University Hospital, and Georgetown University Medical Center.

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b. Nutritional Programs

The DOH Nutrition Services Administration administers several large federal programs to promote good nutrition among low income pregnant, postpartum and breastfeeding women, infants and children. These include:

- The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which provides free nutritious foods, nutrition education and counseling, and health care referrals to pregnant and postpartum women, infants and children to age five determined to be at nutritional risk;
- The WIC Farmers' Market Nutrition Program, which provides fresh fruits, and vegetables to low income women, infants and children;
- The Commodity Supplemental Food Program, which provides donated supplemental foods for low income pregnant, postpartum and breastfeeding women, infants and children up to age 6, as well as the elderly.

Focus on nutritional analysis and manipulation as a behavioral determinant of health and disease, in addition to its recognition as a lifestyle choice issue will become an increasing priority of the DOH disease prevention and health promotion strategy.

c. Use Your Power! Parent Council

This advocacy group educates, trains, and empowers parents to advocate for family-centered services. The Parent Council has succeeded in raising foundation funds to support all operational and program activities. The Parent Council will conduct community workshops on navigating the health care system, using the video and revised pocket map produced in past years, now available in Spanish as well as English. Several workshops will be held in and for the Latino community. The project is organizing a team of 50 consumers, defined as medically vulnerable residents, who are either uninsured or current/former Medicaid recipients. The team's purpose is to facilitate structured and on-going consumer involvement in issues related to accessing the safety net system.

Use Your Power! Parent Council is working with the DOH and providers on outreach and case-finding strategies for D.C. Healthy Families. The volunteers visit schools, clinics, community events and homes to advocate for greater participation in the District Healthy Families program.

4. Adolescent Lifecycle

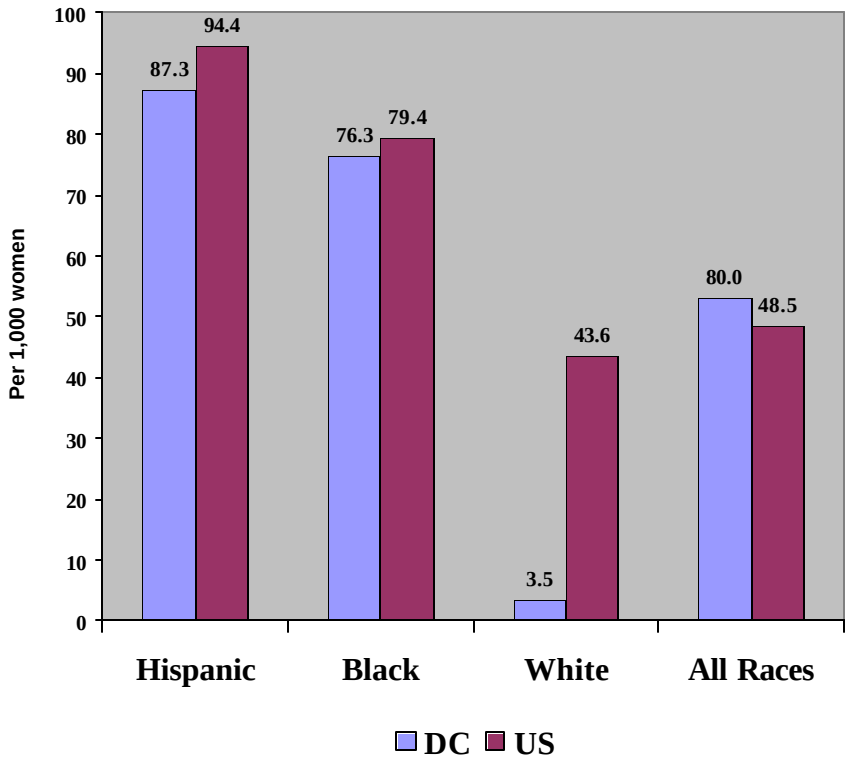
Many pediatric programs—EPSDT, D.C. Healthy Families, the Immunization Program, the School Health Program, and the School Nursing Program—also apply to the city's adolescent population. Adult programs for HIV and STD prevention and peri-natal health also reach into this at-risk population. However several programs are tailored specifically to the adolescent lifecycle, as described below.

a. Teen Pregnancy Prevention

Preliminary Draft

The D.C. Campaign to Prevent Teen Pregnancy was formally launched as a private, non-profit corporation with foundation funding. Modeled after the National Campaign and organized campaigns in other states, it grew out of a two-year effort of the Mayor's Committee to Reduce Teen Pregnancy and Out of Wedlock Births. The campaign's mission is to reduce the teen pregnancy rate by 50 percent by 2005. Figure 10 displays the birth rates for teens, ages 15-19 years by race and Hispanic/Latino origin in the District and the United States.

Figure 10. Birth Rates for Females Age 15-19 Years by Race and Hispanic Origin District of Columbia and United States – 2000



The birth rate for an age group is the sum of live births for that age group divided by the estimated mid-year population of women for that age group.
The teenage pregnancy rate for 2000 was 81.4 pregnancies per 1,000 women aged 15-19 years.

Notes: (1) Persons of Hispanic origin may be of any race.
(2) Black = Black/African American includes women of Hispanic/Latina origin.
(3) White = White includes women of Hispanic/Latina origin.
Source: DC Department of Health, State Center for Health Statistics Administration, 2002.
US Health and Human Services, National Center for Health Statistics, 2002.

A major strategy utilized by the DOH is to mobilize teens to guide and lead efforts to reduce teenage pregnancy.

5. Adult Lifecycle

a. Women's Health Initiative

The mission of the Women's Health Initiative is to ensure that health care resources, such as prevention, educational and clinical are accessible and available to safeguard the health of women in the District of Columbia. Health has been broadly defined as encompassing a holistic and life cycle perspective whereby health is more than the absence of disease or disability rather it is the maintenance of social, physical and psychological well-being (World Health Organization). The cornerstone of the initiative is promoting coordination and collaboration within the DOH and with other public and private agencies and organizations that collectively address the unique health needs of women.

A key component of the initiative is to collect and analyze women's health data and to promote services and support for community-based activities that improve the health of women. Specific areas of concentration include:

- Reproductive and pre-conceptual health;
- Raising awareness of child sex abuse; and
- Reducing and preventing tobacco use among young females.

The Women's Health Initiative will continue to collaborate and build community partners to improve the health of women and expand their awareness. The Women's Health Initiative has compiled a data book on health statistics of women using both local and national data sources. The information will be used to establish benchmarks for the District and to produce a two-page fact sheet for distribution throughout the city. The fact sheet will highlight the issues of health disparities and can assist in identifying the health needs of women.

The D.C. Department of Health will sponsor quarterly workshops through the Women's Advisory Committee and during the annual Maternal and Family Health Conference.

Working with the Reproductive Health Initiative, the Initiative will develop a framework to strengthen this new component in the Maternal and Family Health Administration. The goals of the Reproductive Unit include promoting acceptance and knowledge of family planning to reduce utilization barriers, improving coordination and integration of family planning services among public health providers and identifying sufficient resources to ensure services available to all women. The Initiative will assist the Reproductive Health Initiative to collect and analyze family planning data, develop feasible objectives, and reduce service delivery barriers in public health facilities.

The Women's Health Coordinator is responsible for operating a DC Youth Movement Against Tobacco project funded by the American Legacy Foundation. The grant will

contract with a local non-profit organization to establish youth neighborhood teams that will be organized activities that counter cigarette advertising, highlight nonsmoking as the majority behavior, reduce youth access to tobacco products and communicate the dangers of smoking. In addition, the Initiative has planned two pilot cessation projects to assist young women to quit smoking. The first involves a local job corps site and the second works with the Healthy Start project to promote cessation among pregnant women.

b. Breast and Cervical Cancer

The Breast and Cervical Cancer Early Detection Program (BCCEDP) goal is to reduce unacceptable high rates through the promotion and support of early detection and free screening services offered through Project WISH (Women Into Staying Healthy). This program provides uninsured and underinsured women with a full range of screening services including the teaching of proper breast self-examination methods, clinical breast examination, Pap tests, pelvic exams, and mammograms. Screening services are available at 26 public and private health care facilities in the Project WISH network of providers.

c. Men's Health

The Men's Health/Fatherhood Initiative is charged with encouraging and promoting a healthier lifestyle for men and strengthening families through the involvement of fathers in the lives of their children.

The DOH's Prostate Cancer Program conducts screenings, public awareness campaigns, health fairs and referrals throughout the city. Screenings and cancer education are provided through contracts with community based health care organizations.

This program has limited appropriated funds, and although screenings and educational outreach have been conducted in most wards in the city, there are some areas with significant incidence of cancer cases that have not been serviced due to lack of funds.

d. Cancer Registry

Cancer is the second leading cause of death among District residents, and a major focus of prevention activities in the city. The mission of the Cancer Registry Program is to collect all occurrences of malignant cancers among District residents and to perform epidemiological studies to understand the factors which influence or cause cancer morbidity and mortality in the District. Information from those epidemiological studies is to be used as the foundation of data-driven prevention and control programs in cancer and related areas associated with the disease.

The Cancer Registration Program is a mandate under two D.C. Laws (D.C. 6-83, Preventive Health Services Amendment Act of 1985 and D.C. 8-157, Preventive Health Services Amendment Act of 1990) that require the reporting of cancer diagnosis and/or treatment to the Director of the Department of Health. It has also become part of the

National Program of Cancer Registries, which contributes to national surveillance registries on all its covered sites of cancer. The Centers for Disease Control (CDC) provides almost 75 percent of the Cancer Registry's annual budget.

e. Disabilities Prevention and Control

The DOH is collecting and consolidating epidemiological data on the distribution of illness, injury and disability in the population and is currently in the process of developing its strategic plan for disabilities prevention and control related to accidental injuries as well as to partial or total disability. The program has two main thrusts: (1) assess and prevent secondary conditions associated with disability and to promote the health of persons with disabilities; and (2) track and monitor health needs of high-risk infants and children under the age of eight.

6. Geriatric Cycle

The DOH Nursing Home Initiative is geared towards strengthening the District's regulatory oversight of the District's nursing homes and assisted living facilities. Through enforcement of federal and state standards in District facilities, the District's long-term goal is to improve the quality of care provided. Activities that support this goal include application of Medicare survey and certification activities.

In addition, the DOH has a program to focus on nutrition. The Senior Farmers' Market Nutrition Program (SFMNP) provides fresh fruits and vegetables through local farmers' markets to an average of 7000 seniors 60 years and older who are enrolled in CSFP.

The programs also encourage the establishment of new farmers' markets and farm stands, especially in low-income areas. The goals of both the Commodity Supplemental Food Program and the SFMNP are the provision of high quality, low cost fresh fruits and vegetables to an average of 9,000 WIC recipients and 7000 CSFP recipients. In addition, the program will increase knowledge of the importance of consuming fruits and vegetables and to facilitate changes in dietary behavior leading to the consumption of at least five fruits and vegetables per day among WIC and CSFP participants and the community.

B. Promoting Health Through Improved Access

1.D.C. Health Care Alliance

The Alliance, a recently created public-private partnership, has improved access to quality healthcare for District residents who lack health insurance and have incomes at or below 200 percent of the Federal Poverty Level (FPL). This partnership enhances access to a comprehensive network of qualified providers, improves access to preventive services, reduces reliance on expensive emergency and impatient health care services, and improves the District's capacity to monitor the quality of health care services to Alliance members.

The Alliance network is comprised of:

- Three hospitals: Greater Southeast Community Hospital, Children's National Medical Center, Howard University Hospital, Georgetown University Hospital and The George Washington University Hospital;
- Chartered Health Plan (to manage patient information/care management and provide primary are services);
- Unity Health Care, Inc. (to provide primary care services and operate public community clinics);
- District practitioners who will provide primary and specialty care services, as well as diagnostic and ancillary services.

The Alliance provides eligible residents with Health Maintenance Organization (HMO) coverage through the Alliance network of neighborhood medical centers and urgent care facilities, a network with approximately 1,000 providers in nearly 100 locations throughout the city. Alliance members will be assigned to a culturally sensitive primary care provider with a sound knowledge of vulnerable populations and expertise in the full spectrum of preventive and primary care services across the human lifecycle. Inpatient, outpatient, specialty and diagnostic care will be available at leading medical facilities throughout the city.

2.Safety Net Providers

There are a great number of health care providers in the District that provide care to the uninsured. As of June 2000, Unity Healthcare and the Non-Profit Clinic Consortium (NPCC), together with the District's six primary care clinics, served an estimated 57,000 uninsured individuals (70 percent of total estimated uninsured). The majority of providers in the NPCC and the District's six clinics are primary caregivers with a knowledge base in common chronic conditions. Providers possess a high level of expertise in caring for special populations, including culturally and linguistically diverse populations, the homeless, the mentally ill, the developmentally delayed and substance abusers.

Enabling and support services include outreach and enrollment into D.C. Healthy Families, translation, transportation, Women Infants and Children (WIC) supplemental food program, home visitation under Healthy Start, and case management for many segments of the at-risk population.

The D.C. Hospital Association (DCHA 2000) reports that in 1999, hospitals in the District of Columbia provided approximately $212 million dollars in uncompensated care (charity, bad debt, and other). These figures reported by District hospitals are for both District and non-District residents. Historically, one-third of all uncompensated care had been provided by D.C. General Hospital, which has now closed.

3.Federal Grants Fill Gaps in Safety Net

Federal grants help fill the gaps in the safety net delivery system. The bulk of local grant funding originates from the U.S. Department of Health and Human Services, (DHS), Health Resources Services Administration (HRSA), the agency that administers the Bureau of Primary Health Care (BPHC), which supports community health centers and other providers of community-based primary care. In addition, DHS sponsors the National Health Service Corps, which places physicians, nurses and other professionals in underserved areas.

DHS oversees the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs, the Title V Maternal and the Child Health Program, which funds systems of care for pregnant women, infants, toddlers, children and adolescents, especially those children with special health care needs.

The Bureau of Health Professions, also a part of DHS, supports training programs that increase the diversity and improve the distribution of primary care providers. Also supported by HRSA are organ, tissue and marrow donation and transplantation efforts; telehealth and distance learning activities; and a variety of other resource-building programs promoting better health care services.

Among the programs funded in D.C. by the Bureau of Primary Health Care of HRSA, are the Section 330 Community Health Centers operated by Unity Health Care (Upper Cardoza and East of the River), the Area Health Education Center, HIV early intervention services, the AIDS Drug Assistance Program (ADAP), the Maternal and Child Health Title V Block Grant, and the WIC supplemental foods program. Each of these programs help enhance access to care for vulnerable populations.

4. District of Columbia Medicaid and D.C. Healthy Families

As of July 2001 an estimated 125,000 – 127,000 residents are covered under the District's Medicaid and Healthy Families programs, meaning 22 percent of District residents receive their coverage through either Medicaid or D.C. Healthy Families (MAA, 2001). Data broken down into separate categories from HCFA (HCFA, 2001b) reflect that in fiscal year 1998, children represented the largest single proportion of Medicaid recipients whose eligibility status is known (50.3 percent), followed by low income adults with children (22.1 percent), blind/disabled adults and children (19.4 percent), the elderly low-income (6.9 percent), and children in foster care (1.4 percent).

In 1997, a new federal/state program, the State Children's Health Insurance Program (SCHIP) was signed into law. SCHIP, an expansion program designed to provide health care coverage for children from families whose income is too high to be eligible for traditional Medicaid, but not high enough to afford private insurance (up to 200 percent of the Federal Poverty Level in the District of Columbia) (HCFA, 2001d), seeks to

increase access to medical services as well as important disease prevention interventions.

SCHIP, one of the District's principal strategies to bring health care to economically disadvantaged children, includes not only children whose parents meet this criterion, but parents as well in an effort to provide integrated care to the family and thereby provide an opportunity to bring messages regarding healthy lifestyles and disease prevention strategies to decision-makers in the family[2].

A cornerstone of SCHIP's Health Promotion and Disease Prevention strategy is to systematically conduct culturally appropriate outreach and streamlined eligibility information. To these ends, D.C. Healthy Families has a simple enrollment form available in Spanish and English and requires only one proof of identity and one proof of income. Brochures, billboards, ads on the sides of buses and public service announcements are used to publicize the program and encourage potential eligible persons to call 1-800 MOM-BABY (TDD/TTY 1-877-6PARENT) for more information. Mail-in applications, presumptive and retroactive eligibility and continuous eligibility are important strategies for keeping families enrolled in D.C. Healthy Families.

D.C. Healthy Families provides a broad spectrum of health care services, including prescriptions, vision care and glasses, dental care, home health care, durable medical equipment (DME), health education, mental health, drug and alcohol treatment, and primary, specialty, emergency and inpatient care. Transportation to and from appointments is also provided free of charge.

III. HEALTH AND RISK ASSESSMENT

The District's planning for disease prevention and health promotion as well as control of environmental hazard must be based upon both qualitative and quantitative data analysis. The Department of Health, through the State Center for Health Statistics Administration, the Bureau of Epidemiology, the State Health Planning and Development Agency (SHPDA), and data collection instruments including national-level surveys, has begun to systematize epidemiological data collection such that these data can be utilized for health planning and evaluation. In particular, DOH's responsibility in collecting and analyzing key public health data is instrumental to the development of a fully integrated strategic plan for risk reduction and outreach. Integrated citywide data collection on incidence,

[2] *D.C. Healthy Families* provides free health insurance to working parents with children under age 19, adolescents under age 19 who live alone, and pregnant women up to 200 percent of the Federal Poverty Line. It has as its mission to enroll the estimate 5,601 children and 6,715 parents and pregnant women eligible for this entitlement, for a total of 12,315 enrollees. The plan covers the full spectrum of health care services, including prescriptions, vision care and glasses, dental care, home health care, durable medical equipment, health education, mental health, drug and alcohol treatment, and primary, specialty, emergency and inpatient care. Transportation to and from appointments also is provided free of charge.

prevalence and mortality is key to the development of plans and their subsequent evaluation.

A. Activities by the State Center for Health Statistics Administration

The State Center for Health Statistics Administration has developed a plan of action to support the implementation of an integrated information system that will strengthen DOH's epidemiological surveillance efforts over the next five (5) years. Several key process factors that will help accomplish this will include:

- Standardization of data collection elements across DOH;
- Development and implementation of a Medicaid data warehouse which is compatible with other data warehouses being developed by other DOH agencies, and;
- Development and implementation of DOH data marts.

These efforts will facilitate the integration of the numerous databases within DOH to enable data analysis and health planning. They will also result in a well defined and targeted set of reports, provide access to data in a timely and efficient manner, and enable better planning and targeting of resources.

Over the next five years, while the DOH will continue to support health data collection by the various programs, the ultimate goal is to ensure that such health data are available to the State Center for Health Statistics for analysis and report preparation. Annual reports that could be produced by the State Center for Health Statistics, using various datasets, including the following:

- Children's Health Reports
- Infant mortality rates among infants of mothers under and over 20 years, by race
- Low Birth Weight among mothers over and under 20, by race
- Single and multiple pregnancies by mothers, under 20 years of age, by race
- Elevated Lead Blood Levels in Children (1-5 years) by Race
- Cigarette Smoking Among Adults and Adolescents by Race and Sex
- Sedentary Lifestyle Among Adults and Adolescents (12-17 years) by Race and Sex
- Activity Limitation by Chronic Diseases among Adolescents (12-17 years) by Race
- Asthma Hospitalization Rates Among Children (1-14 years) by Race and Ward
- Adult Health Reports
- Life Expectancy and Causes of Death, among adults 45 to 65, by race and sex
- Death rates for selected causes of death for adults 25 to 65 years of age, by race and sex
- Heart disease death rate among adults 25 – 64, and 65 and over, by race and sex
- Diabetes death rate among adults 25 – 64, and 65 and over, by race and sex

- Stroke death rate among adults 25 – 64, and 65 and over, by race and sex
- Lung, Prostrate, Cervical and Breast cancer death rate among adults 25 – 64, and 65 and over, by race and sex
- Activity limitation by chronic diseases among adults (25 years and above) by race and sex
- Overweight among adults (25 years and above) by race and sex
- Hypertension among adults (25 years and above) by race and sex

B. Bureau of Epidemiology

The Bureau of Epidemiology and Health Risk Assessment is working to build a collaborative data system that links all of DOH's epidemiological functions. Four key information systems provide the foundation of the Bureau's health tracking capability:

- Disease Surveillance and Investigation System;
- Cancer Registry;
- Behavioral Risk Factor Surveillance System; and
- The Division of Disability and the Injury Surveillance Registry.

The Bureau is also working collaboratively to coordinate its data collection functions with other departments, such as, HIV/AIDS, Women's and Family Health, Substance Abuse, and Environmental Health.

Overall, the Department of Health has planned a comprehensive approach to disease prevention and health promotion, by developing the capacity for promoting health data in effective decision-making, program planning and evaluation. Valuable data are collected in many areas but no single agency within the DOH has been responsible for the collection of data, cross analysis, and presentation of this information in an integrated way, as well as data utilization for disease, injury and disability reduction interventions and policy formulation.

Working with other DOH agencies, the Bureau will assess the state of the District's health, analyze historical information and make comparisons and benchmark against other states and the nation in general. This information will be disseminated as reports, strategic plans and in public health journals. An intra-agency committee will be established within DOH comprised of epidemiologists, health planners and policymakers to discuss the epidemiological trends and establish disease prevention and health promotion priorities.

In addition to surveillance systems for bio-terrorist activity, the Bureau is also expanding and upgrading its surveillance systems in order to institute actions to prevent or control the spread of communicable and food-borne diseases. The District is preparing for these outbreaks by building the necessary infrastructure that will allow high quality surveillance and investigation. This involves early warning surveillance systems, epidemic preparedness plans, as well as speedy communications and information sharing.

The current reporting system for infection control practitioners and laboratories is not an electronic system. Paper-based data collection forms are faxed to DOH and entered into the computerized database system. Paper-based reporting systems can lead to long delays in reporting cases to the DOH, which in turn leads to delays in reporting cases to CDC. Like many government agencies, DOH surveillance programs use multiple data sources with different information requirements and separate users. To more effectively monitor the health of the residents of the District, in the absence of one single uniform surveillance system, a standards-based, modular approach to surveillance data will allow the sharing of data across program and disease areas for improved access, interpretation, analysis and dissemination.

The implementation of a NETSS-based (National Electronic Telecommunications Surveillance System) standards approach will also help to ensure that surveillance data meet the necessary confidentiality and security requirements and have the ability to adapt to new technologies, assist in the detection of emerging infections and provide needed information for program planning.

C. Environmental Health Administration (EHA)

Currently, the Watershed Protection Division manages an environmental Geographical Information System (GIS), created in 1993. The GIS was created under contract to Washington Metropolitan Council of Governments (WMCOG) when the District Environmental Health Administration was still under the control of DC Environmental Regulation Administration (DCERA).

This GIS was created with the intent of mapping base layers for the District such as streets, official water bodies, streams, wetlands, soil types, geology, topography, and other base environmental spatial layers. These base layers provide the spatial map for environmental quality data such as water quality, locations of underground storage tanks and leaking storage tanks, and for tracking information related to environmental quality.

The Divisions involved in the development and deployment of the GIS under DCERA included Water Resource Management, Soil Resource Management, Pesticides Hazardous Waste and Underground Storage Tanks. The Divisions currently using the GIS under EHA are the Watershed Protection Division, Water Quality Monitoring Division, Air Quality Division, Fisheries and Wildlife Division, and the Underground Storage Tank Division.

The Divisions utilize a wide variety of spatially related environmental data for regulatory and pollution control purposes. The GIS allows for interactive graphic analysis, overlay analysis, and the quick and efficient display of environmental data. In general, EHA uses the GIS for mapping spatial data for visual analysis, general environmental mapping, presentations, and educational purposes, as well as the reporting of data to the Federal agencies providing funding.

Other key agencies that use GIS in the city are the Office of Planning, Tax Assessor, Records and Deeds, Emergency Management, Police, Fire and EMS, and the Department of Transportation. The Washington GIS Consortium offered services to the city in helping design and implement a city-wide GIS. The Office of the Chief Technology Officer (OCTO) has recently taken over that mission and is completing a city-wide GIS user needs assessment.

A plan has been developed to update the GIS data to be compatible with the new city-wide GIS, which has a host of socio-economic data, and recent updates to the base layers for the city based on new aerial photographs. This plan involves upgrading GIS resources, converting legacy environmental data to a format compatible with the city-wide GIS, making access to the data available over the net, and training users in the basics of spatial analysis using ArcView.

Environmental data is of great importance to the DOH in terms of tracking illness related to environmental pollution, and emergency responses to environmental disasters. In general, GIS could be considered a basic tool of health planning for things such as the location of clinics, measuring the use of clinics, and basic epidemiological studies. Traditionally, these uses are based on socio-economic data that show the relationships between poverty and disease, or the distribution of a disease. Adding an environmental component may highlight issues related to health and environmental pollutants.

Economically disadvantaged individuals often have a greater share of disease; however, the environment, in which they live sometimes contain higher percentages of environmental contaminants than other areas. Areas that have higher levels of environmental related diseases should be targeted first for cleanups and education campaigns. Given the highly confidential nature of public health data, and the laws regulating its use, a cohesive plan of data collection, and aggregation is necessary. Methods similar to those performed by the CDC and the U.S. Census Bureau may be necessary, in order to plan the types of data that need to be collected, and the level of security necessary to control its use.

According to Office of the Chief Technology Officer (OCTO)-GIS, each agency will be responsible for updating its data to the central GIS on a basis relevant to the nature of the data. Not all data are suitable for public distribution in raw form.

D. National and Local-Level Surveys

The District DOH functions as both a state and a local health department. The Department collects and interprets national and local health statistics. The Department uses this data to inform its own planning and program design and aids other public and private agencies and organizations in assessing and planning services that complement DOH's efforts.

The DOH Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Factor Surveillance System (YRBSS) are part of the CDC's nationwide system monitoring a full spectrum of health trends, many of which have been cited earlier in this chapter. Among the core indicators are self-reported health status, including physical and mental health; health insurance status, diabetes awareness and diagnoses, consumption of fruits and vegetables, weight control, smoking status, overweight, AIDS knowledge and attitudes, immunizations, and use of smokeless tobacco. Women's health issues include mammography, breast exams, and cervical cancer screening.

Continuous analysis of BRFSS and YRFSS data allows the District to compare its performance on a wide array of measures to other states and the nation as a whole, overall and by race and sex. This in turn allows for planning and evaluation of targeted interventions to improve local health indicators.

IV. GOALS AND OBJECTIVES

A. Asthma

Goal 1:
Reduce the Asthma death rate to no more than 1.5 per 100,000 residents (baseline 2.8 per 100,000).

Objectives:

1.1 Expand school-based education programs and school-based health information training and messages.

Goal 2:
Decrease the number of emergency room visits and hospitalizations by children with asthma by 30%.

Objectives:

2.1 Develop a program by collaborating with professional societies and health care organizations to ensure increased adherence by the public and health care professionals to recognized primary and secondary asthma management standards.

Goal 3:
Reduce the number of school absentee days attributed to asthma by 50%.

Objectives:

3.1 Disseminate educational information to increase adherence by all providers in the District, to secondary prevention management goals established by national asthma guidelines.

3.2 Conduct pre- and post surveys to determine the effectives of the disseminated materials.

B. Cardiovascular Disease

Goal 1
Reduce deaths from heart disease to no more than 210.5 per 1000,000 (baseline age-adjusted death rate was 263.2 per 100,000 in 1997).

Objectives:

1.1 Identify the main primary prevention determinants of cardiovascular health especially targeting physical activity and nutrition goals.

1.2 Develop a program for cardiovascular health through increased Core and Comprehensive strategic planning in accordance with CDC heart-healthy and stroke-free model.

1.3 Conduct a pre- and post-survey to measure effectiveness of any promotional activities.

Goal 2:
Reduce the proportion of adult residents with high blood pressure to less than 10 percent (baseline 19.3 percent) by increasing the number of residents whose blood pressure is under control.

Objectives:

2.1 Establish and expand the epidemiological surveillance system for blood pressure and heart disease in DOH and provide analysis of demographic, ethnic, and racial populations.

2.2 Disseminate the secondary prevention targets to health care providers and patients with high blood pressure via clinical guidelines and standard of care certification.

C. Diabetes

Goal 1
Decrease the mortality of diabetes in District residents to 22.9 per 100,00 (baseline 28.7 per 100,000).

Objectives:

Preliminary Draft

1.1 Reduce obesity through promotion of healthy nutritional habits among D.C. Residents by providing education at school-based clinics, health fairs and community events.

1.2 Collaborate and partner with the Federal Government, DC Public Schools, Dc Department of Athletics, DC Parks and Recreation, YMCA, and other community groups to implement the program's activities to create The Physical Activity Program.

Goal 2

Reduce mortality of diabetes among African American residents to 30.9 per 100,000 (baseline 38.7 per 100,000).

Objectives:

2.1 Increase the adherence to clinical guidelines and treatment protocols for management by providers and African Americans with diabetes through establishment of standard of care certifications.

Goal 3

Increase to 80 percent the proportion of residents having A1c measurements (baseline 69.8 percent).

Objectives:

3.1 Expand the diabetes screening tools and outreach services through provision at non-traditional sites including churches, community venues, and pharmacies.

D. HIV/AIDS

Goal 1:

Strengthen the effectiveness of HIV prevention programs and practices and expand their scope in order to reduce the incidence of HIV/AIDS among District of Columbia residents, by providing adequate and high quality support.

Objectives:

1.1 Coordinate the procurement, quality control and distribution of condoms in the general population, for specific target groups and in specific social settings where sex is likely to be practiced, by conducting on-going meetings and discussions with HIV community-planning groups.

1.2 Develop and implement a curriculum on sex and sexuality in formal and non-formal education programs focusing on risky behaviors for youth and adults in the District of Columbia.

1.3 Establish and ensure referral arrangements between hospitals and community groups in the treatment and care of HIV/AIDS

1.4 Develop mechanisms that ensure availability and affordability of HIV medication and treatment regimens.

1.5 Conduct pre- and post-surveys of the curriculum of the formal and non-formal education.

Goal 2:
Strengthen the authority of and coordination among youth socialization institutions in order to bring about change in the behavior that predisposes the youth to HIV infection.

Objectives:

2.1 Assess the impact of linkages between schools and communities, and promote communication on issues of education and culture in the social training of the youth through media campaigns that encourage positive values and lifestyles.

2.2 Develop and disseminating culturally appropriate training and information materials on parenting, including guidance of children in school work and social activities.

2.3 Conduct pre- and post-surveys of media campaigns.

Goal 3:
To strengthen the effectiveness of HIV care and support services for women who reside in the District of Columbia.

Objectives:

3.1 Implement culturally sensitive prevention education programs and public campaigns to decrease HIV infection in women.

3.2 Conduct a pre- and post survey to assess the effectiveness of the public campaigns.

D. Immunization

Goal 1
Achieve 100 percent compliance with recommended vaccinations in students at District of Columbia Public Schools (DCPS).

Objectives:

1.1 Develop system to ensure that all DCPS immunization records are entered into the Immunization Registry and share any deficiencies of the child's immunization status with parents and guardians.

1.2 Develop a program to communicate annually to School Nurses and school administrators about the importance of childhood immunization.

1.3 Conduct an evaluation of the new programs' effectiveness.

Goal 2
Improve rates of Hepatitis B Vaccination in high-risk populations.

***Objectives*:**

2.1 Conduct Hepatitis B screening and vaccination at sites that serve high risk populations, including the Sexually Transmitted Disease Clinic, the Tuberculosis Clinic, and substance abuse treatment sites under the Addiction Prevention and Recovery Administration.

2.2 Offer free Hepatitis B vaccine to all patients with HIV/AIDS and uninsured patients who are identified as being at risk through the DC Alliance.

Goal 3
Increase rate of influenza and pneumococcal vaccine coverage in adults over age 64 to 60 percent.

Objectives:

3.1 Conduct public and provider educational information campaigns to increase the awareness of adult immunization for influenza and pneumonia.

3.2 Support and participate in annual influenza immunization drives.

3.3 Establish a work-group to develop a policy to incorporate influenza and pneumococcal vaccine requirements into licensing requirements for hospitals and nursing homes.

3.4 Conduct pre- and post-surveys of any provider educational campaigns.

E. Oral Health

Goal 1:
Increase by 20%, the utilization of dental services by the 81,000 beneficiaries eligible for EPSDT.

Preliminary Draft

Objectives:

1.1 Conduct educational programs directed to EPSDT beneficiaries that increase the access and utilization of dental services.

Goal 2:
Increase the number of practicing dentists in the District that accept Medicaid patients.

Objectives:

2.1 Create educational programs marketed to dental providers and dental students that include incentives that will encourage them to provide their services to Medicaid patients.

Goal 3:
Increase the current percentage (30 percent) of children between the ages of 6 and 9, who receive dental services.

F. Sexually Transmitted Diseases (STDs)

Goal 1:
Reduce the prevalence of Chlamydia infections among persons aged 15-24 years to no more than 3 percent.

Objectives:

1.1 Expand the reach of STD screening and treatment by utilizing school nurses to counsel youth on reproductive health.

1.2 Increase the percentage of partner notification and contact tracing from 90 percent to 100 percent of all STD diagnosed in the District.

Goal 2:
Reduce the incidence of gonorrhea among District residents to no more than 150 cases per 100,000 people.

Objectives:

2.1 Develop effective strategies to help patients modify the behaviors that place them at risk for STDs, HIV and unintended pregnancies.

Preliminary Draft

Goal 3:
Reduce the incidence of primary and secondary syphilis in the District to no more than 3 cases per 100,000 people.

Objectives:

3.1 Create a health promotion campaign focused on reproductive health and STD prevention.

H. Substance Abuse

Goal 1
Establish, coordinate and support a sustainable prevention system to address abuse of alcohol, tobacco, and other drugs (ATOD).

Objectives:

1.1 Conduct culturally relevant needs assessments, utilizing survey instruments, focus groups, socio-economic and health indicators, crime and justice system statistics and data.

1.2 Develop and monitor standards and certifications for technical, professional and cultural competence, by providing in-service training.

1.3 Establish a prevention library and resource center with culturally sensitive materials available to citizens, providers and researchers.

Goal 2
Increase awareness and provide education and training to demonstrate that prevention decreases substance abuse.

Objectives:

2.2 Distribute information to increase awareness on ATOD and youth violence prevention education to 225,000 District of Columbia residents.

2.3 Develop prevention curricula for OPYS staff to use for workshops and seminars on ATOD and violence prevention, life skills, parenting education and related prevention topics.

2.3 Conduct 25 presentations to students in public and charter schools and 500 vendors on substance abuse, violence, HIV/AIDS and public health topics.

2.4 Conduct pre- and post-surveys to evaluate effectiveness of presentations.

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Goal 3
Increase the capacity of community-based organizations to provide ATOD prevention programs and services that are evidence-based and built on principles of effectiveness.

Objectives:

3.1 Conduct a needs assessment of the training and technical assistance needs of community-based providers

3.2 Solicit applications, review and award at least ten grants or contracts to provide prevention programs utilizing one or more of the six CSAP strategies.

3.3 Provide eight technical-assistance workshops, which are responsive to the identified needs of providers and that address areas of program design, implementation and organization leadership.

Goal 4
Establish a comprehensive, targeted and integrated citywide youth substance abuse prevention strategy.

Objectives:

4.1. Collect, analyze and collaborate on substance abuse prevention plans from District Government agencies, intermediary organizations and the Mayor's Interagency Task Force on Substance Abuse, Treatment and Control, to identify common elements.

4.2 Establish benchmarks and outcomes for substance abuse prevention for District youth, families, schools and work places.

Goal 5
Improve the functioning of the Single Substance Abuse State Agency.

Objectives:

5.1 Identify and assess all federal and substance abuse prevention funding streams and resources by collaborating with the Mayor's Youth Substance Abuse Advisory Committee to formulate policy recommendations, coordinate services and leverage and Interagency Task Force.

5.2 Develop and establish baseline data, and procedures for updating the baseline to provide information about under-served populations.

5.3 Establish a roster of qualified trainers, evaluators and other program professionals to provide support to public and private prevention initiatives.

I. Tuberculosis (TB)

Goal 1:
Prompt diagnosis and treatment completion for 100 percent of eligible TB cases.

Objectives:

1.1 Develop a program that increases the surveillance of TB and the rapid identification of cases.

1.2 Conduct targeted testing and treatment of latent infection with special emphasis on the completion of treatment in affected individuals.

Goal 2:
Identification of latent tuberculosis cases especially in high risk populations, with completion of treatment for latent infection in 100 percent of appropriate cases.

Objectives:

2.1 Expand ability for directly observed therapy (DOT) by including non-traditional sites and providers of care. Cultural competency and relevance in providing care and counseling will be maximized.

Goal 3:
Decrease the percentage of foreign-born persons with TB.

Objectives:

3.1 Target culturally sensitive media campaigns towards the foreign-born residents of the District of Columbia.

J. Health Assessment

Goal 1:
Increase the efficiency and integration of the District's epidemiological data, through utilization of the data in health planning and policy formulation.

Objectives:

1.1 Conduct surveillance and investigations of communicable, food-borne and chronic diseases, as well as other health outcomes and analyze the data to determine the extent of disease burden.

1.2 Identify the etiology, utilization patterns and risk factors that predispose individuals within the community to various diseases or health conditions.

Goal 2:
Establish an electronic reporting system for infection control practitioners and laboratories.

Objectives:

2.1 Initiate the development of an inter-agency committee to explore the feasibility of the implementation of an electronic reporting system.

Goal 3:
Expand the Local Health GIS system in conjunction with the development of the Health Planning Data System.

Objectives:

3.1 Develop a work group of DOH and other health agencies to expand the capabilities of the Health GIS system.

Goal 4:
Benchmark the status of the District's health against other States and the U.S.

Objectives:

4.1 Set up an interagency committee to develop a tool for the comparison analysis.

4.2 Implement the tool and publish the document

K. Men's Health

Goal 1:
Expand programs that target health promotion and disease prevention in adult males in the District.

Objectives:

1.1 Initiate the development of a process for the sharing of information by health agencies on health promotion and disease prevention programs that target adult males in the District.

Goal 2:
Increase funding by 25% for men's health and prostate cancer programs.

Objectives:

2.1 Set up an external advisory group to identify sources of funding for prostate cancer programs.

L. Women's Health

Goal 1:
Build a foundation for coordination, support, and advocacy for policies, programs and resources directed at eliminating health disparities and reducing morbidity and mortality throughout a woman's life cycle.

Objectives:

1.1 Create an internal DOH workgroup and an external advisory committee to educate consumers about health issues that affect women.

1.2 Increase the number of uninsured women covered by the D.C. Alliance by expanding outreach efforts to low-income and uninsured women and monitor their utilization patterns.

1.3 Assess the implementation of the American Legacy Foundation grant by developing a community based youth tobacco movement that trains young adults as leaders to prevent initiation among their peers.

1.3 Form partnerships with other government and non-government entities including consumer groups, health advocates, professional organizations, and health care providers to raise awareness and expand capacity to address sexual abuse of young women, and unplanned pregnancies.

1.4 Develop and assess innovative methods of outreach and enrollment that ensure that eligible residents of the District take advantage of both Medicaid and D.C. Healthy Families.

1.5 Develop a tool to benchmark data on women's health in the District and publish a two-page fact sheet for distribution.

Preliminary Draft

M. Children's Health

Goal 1:
Evaluate the effectiveness of current programs to reduce infant mortality and the incidence of low-birth weight infants.

Objectives:

1.1 Conduct surveys in all Wards on the effectives of the programs.

1.2 Increase well-baby care services.

Goal 2:
Develop more effective protocols for reporting sexual abuse of children.

Objectives:

2.1 Develop and implement protocols for reporting sexual abuse of children

2.2. Distribute flyers that describe sexual abuse laws in the District.

2.4 Conduct pre- and post-surveys to evaluate the effectiveness of the flyer

Goal 3:
Reduce the teen pregnancy rate in the District by 50%.

Objectives:

3.1 Evaluate the effectiveness of the D.C. Campaign to Prevent Teen Pregnancy

Goal 4:
Develop a program that identifies, tracks, monitors and provides referrals for services to children enrolled in Medicaid who are at risk of developmental delays and disabilities.

Objectives:

4.1 Determine the exact number of children that are eligible for the Developmental Disability Control Program

4.2 Evaluate records and other documents to determine if the appropriate level of care is being provided to those eligible for the DDCP

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N. Geriatric Health

Goal 1:

Enforce standards to strengthen the quality of care in nursing homes and assisted living facilities.

Objectives:

1.1 Ensure that all inspections of nursing homes and assisted living facilities are conducted in a timely manner.

1.2 Ensure that all patient abuse complaints are investigated and the appropriate action required is initiated.

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